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ABSTRACT

This document contains prepared statements and witness testimony from the Congressional hearing on the economics of aging and preretirement planning. Prepared statements are given by Representatives Skelton and Daub. Topics which are discussed include the population affected, needs of the elderly, and government role. Witness testimony is given by representatives of the Missouri Division of Aging; the Universtiy of Missouri-Columbia School of Medicine; the American Association of Retired Persons; the Missouri Hospital Association; the West Central Missouri Rural Development Corporation; the Cole County Health Department; the Lutheran Retirement Home, Jefferson City, Missouri; and the Foster Grandparent Program. Topics which are covered include the health care delivery system, social planning, social security reform, preretirement needs, volunteer programs, and attitudes toward aging. Panel presentations, as given by representatives of the Missouri Retired Senior Volunteer Program, the Henry County, Missouri Council on Aging, and several Missouri citizens, relate the economic needs of older adults, as viewed through personal vignettes. (BL)

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THE ECONOMICS OF AGING: A NEED FOR PRE-RETIREMENT PLANNING

ED246361

HEARING

BEFORE THE

SELECT COMMITTEE ON AGING
HOUSE OF REPRESENTATIVES

NINETY-EIGHTH CONGRESS

FIRST SESSION

SEPTEMBER 16, 1983, JEFFERSON CITY AND CLINTON, MO.

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THE ECONOMICS OF AGING: A NEED FOR PRE-RETIREMENT PLANNING

FRIDAY, SEPTEMBER 16, 1983

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Washington, D.C.

The committee met, pursuant to notice, at 9:00 a.m., in the Glenwood Room of the Ramada Inn, Jefferson City, Mo., Hon. Ike Skelton (acting chairman of the committee) presiding.

Members present: Representatives Skelton of Missouri and Daub of Nebraska.

OPENING STATEMENT OF REPRESENTATIVE IKE SKELTON

Mr. SKELTON. Good morning, ladies and gentlemen.

I want to thank you for coming to this field hearing of the Select Committee on the Aging. Our topic this morning is "The Economics of Aging: A Need for Preretirement Planning." It may well be the most central issue to be faced by our Nation's efforts to come to grips with an increasingly elderly population in the days and the years ahead. Aging is a daily process and yet we tend to perceive ourselves as always young. While a youthful attitude is sometimes—and always, I suppose—a very positive thing to have and something we always hope to maintain, it mustn't blind us to the reality of changes in our personal finances, in our physical capabilities, in our medical needs and the attitudes of ourselves and our families and our friends.

It's said that knowledge is power and this, in a way, is the point of our hearing today. If we can familiarize ourselves with the predictable changes that are associated with the aging process and we're able to learn to prepare for them, as we prepare from early childhood on, we can give our society the power to overcome the fear of growing old, give our senior citizens the opportunity to enjoy their golden years.

I especially want to thank the gentleman from Nebraska, Congressman Hal Daub, who is here today. Congressman Daub serves on the Committee on Aging, he is one of the leaders in the Nation in the problems dealing with senior citizens. I have been fortunate enough to be at Omaha, Nebr., with the hearing that he called on the Committee of the Aging, and I was most impressed with his knowledge then and as I have seen it from time to time in Congress.

Congressman Daub also serves, I might say, on the Committee on Small Business with me, so we see a great deal of each other in our daily work in the U.S. Congress.

I might also say that besides being a good friend and an expert in the area of aging, he has had a very interesting conversation and communication with Ann Landers, dealing with the problem that you've been reading about in her column recently, so I hope before the day is over, our friend, Congressman Daub, will tell you of his conversation with Ann Landers and how she's wrong in her recent article because I know this has caused a great deal of people to be so concerned and I hope we will have a few moments for him to do that. I especially appreciate Congressman Daub being with us today.

We have some professional witnesses here today. Mrs. Marva Lubker is an institutional advisory nurse with the Missouri Division of Aging. She has given much thought to the matter of preretirement planning and she's been working with me, literally, for several months in trying to devise a comprehensive approach to this problem and I look forward to her testimony today. Dr. Arthur Robins is with the Department of Psychiatry, University of Missouri, at the School of Medicine there. He's been studying the role of the family and society in the aging process and he will outline some of his findings and some of his conclusions. Mr. Arthur Terrel is an area consultant with the American Association of Retired People's Action for Independent Maturity. He is going to address the issue which pretty much controls the direction of one's senior years: personal finances.

Duane Dauner, president of the Missouri Hospital Association. He's very familiar with the trend of health-care costs and of the health-care coverages and he will address the problem of providing health care for the growing senior population. Prolonged illness is one of the greatest concerns and fears of the elderly because it has the greatest potential for decimating the savings and creating hardship for the members of the family. Mr. Charles Braithwaite, executive director of the West Central Missouri Rural Development Corp. is with us. He is an expert on the reserve potential of our senior population. He will tell us about resources and opportunities that are available to our senior citizens to make their lives more fulfilling.

This afternoon, we will have a second hearing in Clinton, Mo. and we will be listening to a number of people in Henry County concerning this very same subject.

Again, I appreciate Congressman Daub being with us today and I would ask if he has any opening comments at this time.

STATEMENT OF REPRESENTATIVE HAL DAUB

Mr. DAUB. I sure do. It's a pleasure for me to be here today. I want to thank Congressman Ike Skelton. He's a good friend of mine and I've observed, watched, and admired his leadership on the Select Committee on Aging in Congress since I was assigned to that committee at the beginning of my freshman term, 3 years ago.

He is sponsoring a very important field hearing in Missouri today, and I want to extend my sincere appreciation for asking me

to be with him. He participated in a field hearing which I held in Omaha, and I am pleased to have this opportunity to reciprocate.

Before I finish with my prepared remarks I would like to make an important point; that is that field hearings are not just for show. I enjoy and have found during my short period in Congress many substantive contribution from field hearings. A field hearing allows a member or two to sit down for a day to liston to constituents. Most of the time, with all due respect to their importance, there is a certain amount of theatrics involved in a hearing in Washington, D.C. We end up having 40 witnesses at 2 minutes apiece in a hearing panel and they all must testify in one morning or maybe a full day in Congress. I, for one, like to listen a little more. I'd like to be able to ask the witnesses a question, or two. So the transcripts of field hearings get more attention from me, personally, and from my staff. I find better ideas and explanations of points of view more rewarding to me and more helpful in doing my job than, what I get out of attending hearings in Washington. In addition, people can't afford to come to Washington and it is important for you to let us know how you feel. We appreciate you being here today and I want to thank you in advance.

As members of the House Select Committee on Aging, Ike Skelton and I both view the Aging Committee as an essential forum for examining the concerns of our senior citizens. These field hearings offer that very important source of grassroots views on the issues facing our older population.

There are many issues that face our country's older population, a population that is growing faster than any age group. Older adults today total nearly 12 percent of our country's population and by 1990, will constitute 15 percent of that population.

As our Nation's population continues to age, it becomes necessary to closely examine the factors that will help us deal with retirement and the effect it will have on our lives. Many of us look toward retirement as the time to spend with our grandchildren or to work on special projects that we've been meaning to do but could never accomplish while we were working.

However, for some, retirement can be a very difficult adjustment. All of a sudden, we have too much time on our hands. Yet one's health and happiness depends on keeping active, whether through individual projects or community service. Senior citizens can contribute helping hands and experience to any community project. Volunteer programs consistently need help and senior citizens often supply the nurturing and caring attitudes needed for those special projects.

Volunteering helps not only the community but also gives senior citizens a feeling of self worth and accomplishment. Many senior citizens can develop their talents into part-time work, which would supplement their incomes. I think that's a very important part of what we have to think about as we look at the next 20 years. While it is difficult when we are young to concentrate on retirement, we cannot undermine the importance of keeping an eye on the future. Retirement age is here before most of us realize it. We must understand the impact that retirement will have on our lives and plan ahead accordingly.

The Government, indeed, has a role to play in the aging of our country's citizens. Government has intervened to help meet the growing needs of elderly in providing income maintenance, medical care, housing, transportation, and social services.

In the past few decades, people have been assured that they will be taken care of in retirement through social security, which has served as a cornerstone of income security. Through the social security changes that were passed in March of this year, and signed into law by President Reagan in April, Congress reaffirmed the commitment on the part of the Federal Government to assure older Americans are compensated fairly for their contributions, both in terms of what's in the fund and in terms of their work product in their retirement years.

In preparation for retirement, it is also essential to think of how one will supplement social security benefits to achieve an adequate retirement, whether it is through private pensions or retirement savings. One avenue is the individual retirement account about which I spoke a minute ago. Following an aging field hearing I sponsored in Omaha a year and a half ago, I found it important to introduce this legislation as a result of the considerable amount of testimony from older women who have worked all their lives but are not treated in the same way that people are that worked outside the home. That's true. The person who decides to work in the home, cooks, washes, cleans, sews, shops, manages the household budget and adds real productivity to our economy. Yet, these people neither get a quarter of credit in social security nor do they receive a W-2 form at the end of the year for that work. My spousal IRA legislation is an idea many are supporting and, again, is a direct result of my field hearing. I just use this example to illustrate the importance of programs and events like we're participating in here today.

Finally, a very important factor, I think, in preparing for old age was most appropriately expressed by a native Missourian and, as I understand it, someone whose roots are right here in your congressional district. Marlin Perkins, whom I think you all know, a celebrity of Mutual of Omaha's "Wild Kingdom," was at the hearing that Congressman Skelton and I had in Omaha. He talked about how one's lifestyle and health practices will have the greatest impact on his or her preparation for old age.

As I have been welcomed by my good friend, Ike Skelton, and, as I welcomed the good advice of his well-known constituent, Marlin Perkins, I look forward today to the testimony and advice that each of the panelists and residents of the "Show-Me" State have to share. I'll talk about "Dear Abby" a little later and maybe I will even talk about a little Nebraska football, if the subject should come up.

I really appreciate this opportunity to join with you today, Ike, and it is my privilege.

Mr. SKELTON. Thank you so much. We'll enter your comments and cut you off before you talk about football.

Mr. DAUB. Missouri's always the spoiler, though, and I always have to worry about that.

Mr. SKELTON. We have five witnesses here today. We are under a time constraint because Congressman Daub and I must fly to Clin-

ton for our second hearing and then he must fly out of there, back to Omaha, so I hope our witnesses won't feel that I'm pushing you along too quickly. I do appreciate your being with us so much.

I spoke with our first witness a few moments ago, Mrs. Marva Lubker, and I told her she was the "George Brett" of our hearing. She's our leadoff. Mrs. Lubker is the institutional adviser in our Missouri division of the aging. We welcome you and thank you for being with us and please take the stand.

I would be remiss if I didn't publicly thank you for the interest, and the information, and the work that you've done in initially getting this hearing to where we are today. I really thank you for your time and effort and we look forward to you adding to our record so that we can take it back to share with the rest of the committee.

STATEMENT OF MARVA LUBKER, INSTITUTIONAL ADVISORY NURSE, MISSOURI DIVISION OF AGING

Mrs. LUBKER. Congressman Skelton, Congressman Daub, I deeply appreciate the opportunity that you have afforded me to address some key concerns that I, as a health-care professional involved in caring for the elderly, feel very strongly about, especially in the area of the economics of aging and the need for preretirement planning.

With our rapid growth in the elderly population, we must, in my opinion, address more thoroughly some basic issues that have a significant impact before we fragment our thinking and begin to deal with that phase of life called retirement and the planning for such.

We must be very conscious and must realize that preretirement planning is a very complex issue and transcends leaving the job force and being economically prepared to do so. We must view the economics of aging and preretirement issues with multiple approaches. We must carefully examine the issues of using resources from all disciplines. We must develop short-term goals and objectives that can begin to make an impact now, if that is possible. We must also develop long-term goals and objectives that can have an impact on the system 10 to 20 years down the road, when the baby-boom people begin to approach the golden years that everyone refers to as retirement.

To do that, it's vitally important that we understand as much as possible concerning the sociological, physiological, psychological aspects of aging. We just have to do this in order to address the economic issues in a satisfactory way. To be psychologically, sociologically, economically, and physically prepared to accept retirement, it appears to me that one should approach retirement planning with the same degree of importance that one gives to planning for life, and that life's planning includes the planning for your education, planning for your ensuing life career.

If it is natural for a child to ask over and over again the questions during its formative years: "What will I do when I grow up," why should it not be just as natural for a young adult in the process of establishing his or her career, to ask the same type of questions: "What will I do when I retire?" Successful preretirement planning is contingent upon understanding issues and must have

strong involvement from education at all levels throughout the life cycle.

In the absence of extended family relationships in our society today, does the school system in kindergarten through 12 have any responsibility for changing the attitudes of our society toward the aging process? A resonsibility that I see that could instill all along that educational structure an understanding that aging begins at the time of birth. It is ongoing and must be dealt with at each stage of life, not just something that is confronted for the first time just prior to realizing that you're ready to leave the work force.

Many professionals trained today are inadequately prepared to deal with the problems of the aged. They do not see old people as attractive clients and develop strong biases against offering services to them. We all know that a number of diseases and conditions of old age can be treated and often turned around if they are properly diagnosed.

Preretirement planning must consider the health-care-delivery system. It is know that chronic conditions are more prevalent among older persons than younger and that the elderly have a 1 in 6 chance of being hospitalized during the year than persons under 65 having a 1 in 10 chance.

Do the framers of public policy have a responsibility to improve or sometimes initiate where it's not in existence the content of basic health and mental health aspects of later life in our professional education training programs? And should we maybe not develop a system that includes, for example, financial assistance to those schools of medicine and nursing, social work and psychology that truly demonstrate an interest in integrating geriatrics into their curriculum?

Without that understanding, we cannot fully focus upon the issue of preretirement. How can Government become more actively involved in a public education campaign that aids in eliminating the myths and stigma of aging, myths and stigmas that lead people to believe that depression, senility, and old age are synonymous, inevitable, and incurable? How can we change the attitude of a think young and think thin society to really and truly accept old people for the value that they are? How can we instill the idea that our forefathers had about the wisdom, the sage wisdom of the tribal leaders?

More than one-third of the dollars spent nationally for personal health-care is spent for older persons and per capita health-care costs are nearly three times as much for older persons than those for younger adults. Would this not indicate, then, a need for a stronger public health approach to dealing with health-care problems in our country, with much more emphasis placed on preventive measures that develop and help maintain a state of wellness, especially in our older citizens?

It does no good to have all the time and money in the world in retirement if individuals are in such a poor state of health that all enjoyment is gone.

It has been documented throughout the literature that the elderly also have the highest incidence of mental illness of any age group. Nationally, 13 percent of the elderly population have severe mental health problems, as compared to 7 percent of those adults

18 through 64. Furthermore, an estimated 50 percent of all the persons in nursing homes show evidence of some type of psychiatric impairment. Yet few services have been developed to truly address the mental-health needs of the elderly.

Does Government have a role in the development of a service delivery system that includes mental health services as an integral part of that delivery? Preretirement planning must also consider and begin to address longstanding sociological issues and their impact.

How do we cope with the double jeopardy experienced by older, minority Americans whose situation often only reflects the disadvantaged status of their youth? Those who are trapped by these unfortunate circumstances most often will face a bleak future unless ramifications of the problem are more understood and responded to by those who can facilitate change. These workers have often, early on, been excluded from social security benefits and pension benefits and are now in positions of having to survive on a very limited income. Congressman Daub addressed the issue of the older female who has spent her entire life's career caring for others in the home situation.

In a presentation before the Ozark Regional Commission's Governor's Conference on Aging, Gary Hendricks, of the Urban Institute of Washington, D.C., presented some statistics that were eye opening. Mr. Hendricks projected that the growth in the labor force between the years 1980 through 2000, will be 23 percent. Between 2000 and 2020, growth will be about 11 percent, and between 2020 and 2040, growth will be less than 5 percent. At the same time, the proportion of people who are elderly is also growing. This growth will stay fairly constant through the year 2000. And by 2010, the first group of postwar baby-boom people will begin to retire. By 2015, these people will begin reaching the current retirement age en masse.

Currently, approximately five persons support one person who is of retirement age, whereas, by the year 2020, we will have about three persons for every retired person. The implication of these statistics is that this country now has a large number of persons crowded into the entry level of the labor force, creating an underemployment problem. By 1990, all of these people will be moving into the middle level of their career paths. When we reach 2015 and they reach the current retirement age of 65, the Federal budget will be even more strained. This could mean that as much as 60 percent of Federal spending could go to meet the needs of the elderly.

It would appear, then, that the economic challenges of the elderly in the 1980's and beyond, give us no choice as we begin to think about preretirement planning for this group of citizens, that we examine carefully retirement practices, both public and private, and study the possibilities of development of uniformity in pension benefits and standard criteria for those benefits. Examine what conditions cause older workers to seek early retirement, rather than continuing in the labor force. To continue to stress longer employment which would ease the burden on the social security system through delaying benefits and increased input by continued

employee/employer contributions. Encourage the formation of preretirement planning programs, both public and private.

In a recent survey that I reviewed, data indicated that 70 percent of those people interviewed had a desire to participate in such planning. We must examine the impact of the current tax structure on the elderly, since taxes affect each elderly individual by either cutting into his spendable income or by providing some of that income.

With these few recommendations, I have only begun to scratch the surface of this gigantic issue of planning for retirement. I am pleased that the Select Committee on Aging continues to be vitally interested in the Nation's elderly with specific emphasis at this time on the economics of aging. With technology of today continuing to add quantity of years to the lifespan, this Nation's elderly now enjoy, should we not generate just as much energy and resources toward the quality of those years?

Mr. SKELTON. Mrs. Lubker, obviously, you have given a great deal of thought to your testimony. It is very, very comprehensive and were we to have the time, we could undoubtedly spend a good part of the morning asking you questions about it. But because of our time limitation, I am going to ask just a few, touch on just a few items that I wish to explore with you a bit further.

You spoke about the psychological and sociological problems that come about. I think we're probably more familiar with the so-called psychological syndrome that we might have. Could you tell us some of the sociological problems of aging, as you see them?

Mrs. LUBKER. Well, I think, as Congressman Daub, we have an issue of older women. The economic well-being is often contingent upon the economic successes of her spouse and how well her spouse planned for retirement. We have, in that same group, minority population of blacks, who, because of their very life cycle early on and the types of employment that they have been able to be engaged in, find themselves at the lower end of the economic sector. We find the very attitude toward aging, in my opinion, is one of the biggest barriers to developing services for, on a short term, the elderly citizens of today. When we have our American attitude, as I said, totally geared in on "think thin and young," and if you happen to be a little pudgy and a little gray, you're just not quite with it.

I think we have a responsibility to begin somewhere in the long term to begin to turn that attitude around and to begin to respect the value of being the sage of the tribes.

Mr. SKELTON. This, of course, is a good phrase in the study of many cultures, including, of course, the study of the American Indian culture, is quite true.

You mentioned a few moments ago the myths and stigma of old age and I might share an interesting experience I am having right now, as Congressman Daub knows. I am in the process of trying to revise the Joint Chiefs of Staff operation in the Pentagon. And, needless to say, it's a monumental piece of work. I'm having some luck and I will tell you who my mentor is in this project, a Missourian, 83-year-old former Chairman of the Joint Chiefs of Staff, Maxwell Taylor, who literally, line by line, went over my bill and made corrections from commerce, on up, and I am amazed at the

impact of his leadership on me and his inspiration on me and, actually, we're getting on second base in the project. But for this gentleman who I would really say is 83 years young—I would not be having the good fortune I'm having thus far in the Armed Services Committee on this very vital subject. So when we speak of myths and stigmas, it's not touching that Missourian.

Have you any comments on the myth and stigma problem?

Mrs. LUBKER. Well, there are so many people who think that one should begin to be old, that everyone wants to sit in a rocking chair and enjoy thinking about what has transpired in their age prior to retirement.

Aging is just like any other issue. It's an individualized situation. Not everyone has the same aging process at the same level. Not everyone is ready to retire at 65. Not everyone is ready to sit down and watch life go by. And we have to begin to think more positively about the values of people, just as the gentleman you expressed so much optimism about.

You really cannot begin to do that unless it begins very early in a youngster's formative years, in my opinion. You don't all of a sudden begin to teach someone who has feared and dreaded the thought of getting old because getting old means the nursing home, getting old means all of these diminishing capabilities, whether it be from your ability to compete in the job force, to your ability to compete athletically, whatever. We have to change the attitudes and that's the myth that I speak of, the stigma of employment and all of the issues that older people face.

Mr. SKELTON. One bit of information for you that my able assistant just told me, the Office of Technology Assessment is doing a study on the impact of technology on aging and this study should be ready in February 1984, so if you put that in the back of your mind, I know that you would want to read that.

Congressman Daub.

Mr. DAUB. I very much enjoyed your contribution to the record. I want to point out on page 3 of your testimony, you refer to the year 2015. However, should there be no change in current law, we will be recalculating our Federal expenditure figure from the social security trust funds. These figures will be based on the fact that by that time we will consider the age of 66 and 67 as the magic retirement date for social security purposes. This is because, as you know beginning the year 2000, we will commence to raise the retirement age to 67, phased into the year 2024. This change will have an effect on the Federal budget in terms of the amount of the expenditure level which, if not changed, would be 60 percent. Now I think this expenditure level is somewhat less than 50, in the range of 47 percent.

That is not at all to dismiss the point you made in the paragraph, which is true. A giant sum of money will be devoted to older Americans' transfer payments.

Mrs. LUBKER. That's the point.

Mr. DAUB. The point of your sentence, to be sure, is that there will be a major change in those figures because of the phasein of the retirement age, which will be increasing beginning in the year 2000.

As this is the area of your expertise, are there any places where someone can go to get preretirement counseling?

Mrs. LUBKER. There are a lot of corporations who have preretirement planning programs. There are a lot of aging specialists with university systems who have the information on preretirement planning. Dr. Warren Scott, for instance, who is with Lincoln University, has been involved in the need to deal with preretirement planning. Dr. Vaughan, the Center for Aging studies at the University of Missouri, has been instrumental in wanting to formulate more active involvement.

Mr. DAUB. Is there someplace where just the average person, can get this counseling? I am not referring to senior citizens. Whatever that means, remember, once you get there and you haven't had preretirement counseling it may be very difficult to do. What can that person who is 50 years old, or 54, or 55 years old do? Is there a place where the average person can go that's available, that people know about to get preretirement counseling?

Mrs. LUBKER. I am not sure.

Mr. DAUB. If any of the other witnesses heard that question, I would certainly appreciate the contribution to the record. One of my suspicions is that there aren't enough places anywhere in the country where people can knock on the door. and get this type of counseling. The Association of Retired Persons, Federal retiree groups, railroad retirement groups, and farm and agricultural organizations from time to time sponsor seminars for older Americans. The topics include how to invest what money you may have in your nest egg, but beyond that they do not include a lot of the sociometric things you're talking about which I do think are very important.

Mrs. LUBKER. There is a variety of insurance companies, private employers have dealt with it on the fringes but with no real organized approach to dealing with preretirement planning.

Mr. DAUB. I very much appreciate your contribution today. Thank you very much.

Mr. SKELTON. Thank you so much, Mrs. Lubker. We truly appreciate your help, not just today but in assisting us early on in this hearing.

Dr. Arthur Robins will be our next witness. Dr. Robins is with the Department of Psychiatry, University of Missouri—Columbia School of Medicine. In fact, when I went there, it was just the University of Missouri, but now we have to designate where it is. And, as Congressman Daub points out, from time to time we will spoil the good record of the Big Red from Nebraska, and let's hope that happens.

Dr. Robins, thank you so much for being with us.

STATEMENT OF DR. ARTHUR ROBINS, DEPARTMENT OF PSYCHIATRY, UNIVERSITY OF MISSOURI—COLUMBIA SCHOOL OF MEDICINE

Dr. ROBINS. Thank you for inviting me here. I should explain that I am not a psychiatrist, actually a social worker by education and I was for a time, 17 years, or so, in the School of Social Work

at the university and then switched fields, I guess getting ready for my retirement.

I have been intermittently active in research and teaching in the field of gerontology since 1958, when I was a faculty fellow at an interuniversity institute on social gerontology, designed to stimulate bright and young faculty and research and teaching in that field. It's difficult to imagine me as bright and young now, but I combined my interest in the family as a social institution with aging and then subsequently did studies in the three-generation family, in which I became interested by virtue of experience in India, where I was impressed with the joint family system and its effectiveness in meeting the needs of its family members.

My main function now is as a research consultant to the psychiatry faculty and some of my work includes work with the aging but not a great proportion of it. I want to make three points: first, that research has an important function in social planning regarding the aging; sound research can define the situation that the aging people are in, and can reveal the status of the aging—their biological status, psychological status, and social status. It can separate myths from realities, to borrow the term from a study done by Harris Associates in 1974, for the National Council on Aging. I would like to refer to some of the salient points of that in a little while.

The second point I want to make is that even though I make my living as a research consultant, research has a limitation. It can provide a picture of the level of life that is the actual situation that the aging is in but it doesn't tell us anything about the standard or the level to which we should aspire. In other words, research can evaluate the extent to which a program achieves a goal and it may indicate which is the most efficient of several alternative ways of getting there, but it doesn't provide the goal. That goal comes from our values which determine the quality of living that we want for our aging population and that is really what I wanted to stress in my testimony.

The third point is that one value which I think should inform all of our efforts in behalf of the aging, namely, a commitment to the interdependence of different generations. Someone said that the truly mature person is neither dependent nor independent. He recognizes his interdependence with other people. I would like to reaffirm this principle which was enunciated in a background paper for the 1961 White House Conference on Aging and referred to in a report of that conference. The Committee on Family Life, Family Relationships and Friends produced this statement which I think should serve as a criteria by which all programs purporting to help the aged should be assessed:

> Whenever a society and its families with support of the prevailing culture can create and sustain mutually supportive relationships between its youth and its elderly, old age security rests on its firmest foundations.

I don't think we've always looked at that principle in some of these aging programs that have been developed.

Now I would like to turn to some of the general findings of research relative to the myths and realities of aging, which I draw

from a study done in 1974, by the Harris organization for the National Council on Aging.

Essentially, what they did was to examine public attitudes toward older Americans and the expectations of the public of what it is like to be old in this country today and it also looked at older Americans themselves and their personal experiences of old age. Essentially, comparison of the responses of the public with those of the aged reveal the great discrepancy between what people who are not aged thought aging was like and what the aging report about what aging actually was.

It's not surprising that the public views aging as a much more dismal time of life than older people say it is. As I become older myself, I increasingly realize that there are a lot of older people around who are doing very well in many aspects of their lives. My only intimate contact with older people was with my father and my mother-in-law, and both of them were productive and vigorous almost to the day they died. I had considered them to have been exceptional.

As a social worker, when I was in public assistance and in psychiatric hospitals, I saw older people whom I assumed to be the rule rather than the exception and I shared the stereotype that one had to shout at in order to be heard and that they had to be treated like children. That stereotype still exists. My daughter was hospitalized recently for a brief illness. I visited her frequently and overheard how the nurses talked to the older patients in ways more appropriate to dealing with a 5-year-old.

While society tends to view older people as a homogeneous group, the findings of the Harris study emphasize the heterogeneity of the aging. Most older people do not suffer so seriously as the public thinks, although certain subgroups of older people do have a difficult time. Obviously, the elderly poor have difficulty getting adequate medical care, housing, and clothing. But the problems with the elderly poor are the same problems with the middle aged and younger poor. They are the problems of poor people. For example, the study found that 44 percent of those in the age bracket 18 to 54, who had incomes under $7,000 a year, had money problems. whereas only 20 percent of the 55-year-old group whose income was $7,000, or less, had money problems. So that if we have to consider, as Mrs. Lubker said, that older people have to be individualized. A lot of them have probably paid off their mortgages, have more modest needs, more modest expectations, and generally need less money.

In only three areas did the older people as a group appear to suffer more serious problems than the young, and that was in the fear of crime, poor health, and loneliness. And in those areas, income and race accounted for the problems more than age, itself. In other words, older people as a group feel no more burdened than did the younger people about problems of not having money, not enough medical care, not enough education, poor housing, not feeling needed, not enough friends, not enough to do to keep busy, and not enough clothing.

Now, having said that, I want to point out that a completely rosy picture of aging would be misleading. As the president of the National Council on Aging pointed out, it's important to remember

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that when 15 percent of people over 65 say that not having enough money to live on is a personal problem, that means 3 million people have a serious problem. However, the implications for policymaking are that programs designed to help the aging must be directed toward the 3 million who have a problem, rather than the entire 20 million. Limitations on our resources call for setting priorities. Many have discovered, to their chagrin, that the social security system is not a true pension or a self-sustained system, and there are gross inequities in it. I think that a means test, which I know many social workers are automatically against, may not be amiss.

The study has a section on preparation for old age, which is relevant for the purpose of the hearing and I want to quote from that. For every older person who feels that his or her own life is worse now than what he or she thought it would be, there are three who say their life is better than they expected. In fact, as many people under 65 feel that their current lives fall short of their earlier expectations as those 65 and over. Income and race seem to have more to do with how life turns out than age itself. And since income and race are highly correlated, it is probably income that's the biggest factor in determining whether aging is better, worse, or about the way it was expected to be. One in three older people have been pleasantly surprised with their later years. Many of the problems they feared never materialized. They talked about their financial security, having more money than they expected, good family life and marriages, good health, and general comfort. The study asked what was the most important step to prepare for retirement. The 88 percent who thought medical care was important had already taken that step. The 85 percent who thought it was very important to learn about pensions and social security had already done that. The 75 percent who said it was very important to buy their own home, had already done that. The 61 percent who said it was very important to have hobbies and other leisure time activities had already done that. The 7 percent who thought it was very important to move in with children had already done that. There are four areas in which the older public appear to be less prepared than it thought it would like to be; 85 percent said it was very important to build up savings but only 73 percent had done that; 79 percent said it was important to prepare a will but only 65 percent had done that.

Planning new part-time or full-time jobs had been considered important by 26 percent but fewer had done that. The study found that those who were least prepared for their later years are older people with incomes under $3,000 and blacks and these two groups overlap considerably, in view of the high correlation between income and race.

I stress the importance of deriving program goals from what our values tell us about the quality of life older people should have. We may find that planning for satisfying retirement involves more than gratuitously advising people to do the things most of them have already done, like learning about their future benefits or even advising them to do the things they know they should do but do not like to confront like writing a will. I'm 62 and I wrote my will only last year, a very brief one. It's probably not worth very much.

Preretirement planning is more than distributing a Government phamphlet on how to have fun with powdered milk. I think planning has to deal with societal values and individual attitudes that reflect those values. It is revealing that only 6 percent of the aged consider the decision about living with children to be an important one. In our society, I think we have overvalued mutual independence of the aged and their adult children.

Now, I'm aware that research has shown that older people want independence. Two researchers who found that older people wanted independence asked this question: "Why plead the cause of social patterns with a system of norms which the older person, himself, no longer accepts?" Well, I am suggesting our task maybe is to change that situation. In 1940, another sociologist asked the question, which is still unanswered:

> Are we to continue the attitude indicated so clearly, even in the thinking of upstate New Yorkers born before 1860, namely the high evaluation of the aged from their family and their relatives? Must older persons necessarily be an annoyance to younger persons who wish to live their lives in their own way? Is there not opportunity here for new patterns of living by which the aged can live with the young and have certain personal independence without mutual annoyance?

I don't think we've ever really answered that.

I do not want to portray the American elderly as isolated and rejected by families. A number of studies have shown that, although there is a pattern of separate households, there is a supportive pattern of family relationships. I don't doubt that a number of older people do move in with their kids when they have to and the children accept them. But the point I wanted to make is to go back to the 1961 principle. The three-generation living arrangement does not have the support of the prevailing culture and frequently such demonstrations of filial responsibility as three-generational living are subject to a great deal of strain. My point is it doesn't have to be if we change societal values. For one thing, the middle generation has new aspirations for self-fulfillment and self-actualization that the older generation may inhibit. Everyone wants to go out and work for a living. It's been pointed out here that the business of being a housewife has stigma.

Members of the older generation often have no socially approved roles to play in three-generation households. Then they feel themselves to be very inadequate and they find they have to prove their adequacy only by becoming meddlers and trying to play roles in the household for which they are no longer competent or which conflict with the roles of the second generation, going around dusting after the daughter-in-law and that sort of thing. It's no surprise that studies find that older persons express the desire to be independent of their children. Older persons reflect the values of their culture.

I was certain, for example, that my aging father wanted to live with my wife and me. We wanted him to live with us and we bought a house big enough for him to move in. But do you think he would tell a researcher that, "I want to live with my son and his family"? No, because in Romania, where my father came from, it was OK to think in those terms and even expect it but my father had become an American and in modern America, older persons are supposed to live independently, whether or not it's the best ar-

rangement. And I think the tragedy is that so long as independence is a prevailing norm in our culture, intergenerational living arrangements will be beset by emotional strain. The family as a social institution has the function of providing emotional and physical shelter to its members and I think any social programs that are developed for the aging should help to strengthen the family's capacity to fulfill that role.

I suggest that any preretirement services attend carefully to the reinforcement of complementarity in the relationships between the generations. I am not suggesting that we go back to some earlier period in our history when three-generational living was prevalent. For one thing, it is dubious that that was ever a common way of life. I am suggesting that we need new norms. In 1912, at the first White House Conference on Children, there was a principle established that the natural parent-child relationship had values for which there were no desirable substitutes, so that children should be kept with their natural parents whenever possible. Child welfare programs moved progressively through farming out, indenture, care in almshouses, orphan asylums, foster and boarding homes, to the emphasis on keeping children with their natural parents while providing individualized services aimed at remedying any of the inadequacies of the parents.

I say we need to promote the development of services in the same way for those aging who need it, that we maximize the capacity of family generations to be mutually supportive and services that will provide family substitute care for the old person. I think the culture must support a family role for the aged that provides some means of feeling adequate so they don't have to resort to troublesome roles which interfere with familial solutions to the problem of aging.

As Bengtson and Treas, who wrote a chapter in the "Handbook of Mental Health and Aging," a comprehensive book, have said: "Public policy and practice must emphasize the ways in which families may be enhanced as support systems for the elderly, meeting both the subsistence and emotional needs of aged kin."

I just want to make a point briefly that preretirement counseling is something for the whole family. I think you just can't expect the adult to go in and plan without considering all of the family situation. In other words, the focus, I think, should be on the family as a supportive network because I think that if we go to developing Government services, we'll never have enough resources to do that unless we make use of an institution that is supposed to give physical and emotional shelter to its members, namely the family. Thank you very much.

Mr. SKELTON. Thank you so much, Dr. Robins.

I will ask Congressman Daub.

Mr. DAUB. That was just terrific testimony.

Dr. ROBINS. Thank you.

Mr. DAUB. We really appreciate that and I want your address. How do we get in touch with you beyond this designation here?

Dr. ROBINS. I will give you a card.

Mr. DAUB. I was fascinated—and I think I saw Ike write it down at the same time I did—by your suggestion. Again, maybe social workers, with all due respect, have some of the same stereotypes

about processes that others in our society have about aging. You said we ought to possibly think about means testing or did I hear you incorrectly?

Dr. ROBINS. Means testing is a dirty word in social work, or was. I haven't been active in social work. In 1971, I got repotted. It was inadvertent but it was good for my retirement. I left the School of Social Work to head a multidisciplinary program for advanced study in mental health. So, I haven't been intimately connected with what's going on in social work. But at one point, the idea of a means test was sort of reprehensible in social work. They wanted to establish that everyone had the right to programs and didn't like the idea of demonstrating need. But I think we've learned that we don't have infinite resources and that if there are 20 million or so aged people in this country, that they are not a homogeneous group and that there is only, say, one-sixth of that group that needs real help. I think that in social work, we tend to see the problems and think that everybody has them. I was guilty of it myself. I used to sit down and talk to an older patient and scream at them when I didn't need to in order to be heard.

Mr. DAUB. You know, in the social security reform package that we just passed, it essentially, commenced to move in the direction you suggest. That is, with respect to the entitlement to social security benefit there is now a degree means testing. We will tax one-half of the social security check if, in fact, income subject to tax—in a single-person case in retirement is over $25,000, or in case of a married person filing joint return, income exceeds $32,000. We begin to look at the transfer payment and who ought to receive benefits and how much everyone should receive. I think you will also see this situation in the medicare/medicaid debate which will rage in the next 2 or 3 years. This idea was suggested, you will remember, in our full committee meeting, by the Secretary of the Department of Health, Education and Welfare who at the time was Joe Califano. He very strongly suggested and recommended to the administration then that the idea be examined carefully and that we need to target our resources and establish greater priorities. Although not accepted then, his thinking is coming more and more into the norm now.

Dr. ROBINS. Well, a means test is assumed to be degrading. I don't think it is. We all have to demonstrate our eligibility. When I go for a loan, I need to demonstrate it. I don't consider it to be a degrading thing. I think older people can deal with that very easily. The old age assistance program is called a pension. It's not a pension, it's a grant, a welfare payment and yet they call it a pension and that makes them feel better and they deal with their feelings.

Mr. DAUB. My last point is one that you raise, I'm a product of a three-generation household. After World War II, my mother's mother and father moved in with my father and my mother. I was born and raised in that household until grandma passed away and grandpa, because of very severe intensive care requirements, had to go to an institution. I found it to be a worthwhile experience but, quite honestly, we had a tension problem because grandma would follow mother around the house, dusting things that she had dusted, like you said, and pointing out that my ears weren't

washed or my hair wasn't cut or, you know, kind of getting in the way.

Dr. ROBINS. You're spending money the wrong way.

Mr. DAUB. Yes, and the commentary over the years got to be difficult. I know that you really make a good point and we need to elaborate on that subject as one by itself, because there are those asking if we should means test? That is to say, should we give a credit on income taxes for taking care of a person over 65 or 70 in our home. Also, should medicaid, the State payment, be allowed to require, at the State's option, a contribution from a son or a daughter to take care of the medical needs of their mother or father in old age? There are a number of issues now on the table that could deal with this sociometric living pattern of three-generational living in one household. I really encourage your continuing interest in that field. You're going to hear from me in the future on that subject.

The last question I want to ask is whether we should make the cost of tuition or the payments of a fee for registration, books and materials for a preretirement seminar tax deductible?

Dr. ROBINS. I think that's a good idea. I think the people need to be encouraged. I don't think it's only the financial costs of preretirement planning that discourages people from going into it. But I think there are other obstacles some people do not want to confront in a disciplined way. While tax credits may encourage some to do more planning, the poor aging who primarily composed the group that had not planned, might not benefit much from tax credits if they don't have taxable income. Also, planning presupposes some alternative choices which, if not available, render planning to be an academic exercise. This suggests that we need programs that increase the range of choices, for example, low-interest loans for more renovations that facilitate intergenerational living arrangements.

Let's pot overlook the fact that a lot of people have made adequate plans for preretirement. I think that you have to determine whether you want to address the 3 million people or whether you want to address the entire 20 million.

Mr. DAUB. Good point. Thank you very, very much.

Mr. SKELTON. Doctor, thank you very much. The main question I had and my friend from Nebraska already asked you, and that was the means testing and I appreciate your comments on that.

As I was growing up in Lexington, one of my very best and closest friends through the years was the son in a four-generation household and this was through to his senior year in high school. And being in the home literally dozens of times over the years, a very harmonious, wonderful environment for him and I can guess that today he is the beneficiary of not only a lot of wonderful memories, but an awful lot of sage advice coming from his great-grandmother, his grandmother, as well as his fine parents.

Doctor, thank you so much.

Dr. ROBINS. Thank you.

Mr. SKELTON. Our next witness is Mr. Arthur C. Terrel, area consultant, American Association of Retired People, Action for Independent Maturity.

Mr. Terrel, we appreciate your being with us today. And let me interject, if I may, sir, Congressmen always have to take the credit for all the work that's done and, quite honestly, we have some very, very able people working on our staff. I'd like to introduce Mrs. Toni Arnett on my far left, who is my legislative assistant in my Washington office, who is my expert in the area of aging, as well as health care and related issues and if I vote right, give me the credit; if I vote wrong occasionally on the issues, blame Toni.

The gentleman on my right, Mr. Lowell Arye, who is with the Committee on the Aging. He is the research assistant on the Subcommittee on Retirement Income and Employment. We appreciate him coming from Washington and a great deal of his recent weeks have gone into planning this particular day.

Mrs. Anne Kutcher, who is the young lady who is in charge of our Jefferson City office and makes everything run smoothly, not just in that office but today, and her very able assistant, T. J. Seibenman, who is hiding in the back of the room. We just want to acknowledge and thank you for making this so easy for Congressman Daub and me.

I might say that I hope we might have some time for questions and hope that the witnesses can maybe summarize just a bit, we'd appreciate it.

ARTHUR C. TERREL, VOLUNTEER CONSULTANT, ACTION FOR INDEPENDENT MATURITY, AMERICAN ASSOCIATION OF RETIRED PERSONS

Mr. TERREL. Congressman Skelton, Congressman Daub, I certainly appreciate the opportunity to be here today. The things that I bring to you in my written testimony and comments I make are things that I've derived out of my experience in business and work with the American Association of Retired Persons and as AIM volunteer consultant (Action for Independent Maturity), a division of the American Association of Retired Persons.

I feel that there is no greater factor in assuring better later years than a well-designed and implemented preretirement program, particularly in the economic area.

Over the past decade, there has been quite a bit of work done in preretirement planning but, in my view, it has been too slow and part of this has been because of the recession and because of the attitude of some business managements. I feel that the larger responsibility for the implementation of complete and well-designed retirement planning programs is in the business and industrial community. And, indeed, many larger companies have implemented their retirement programs and have resulted in a great benefit to their employees.

Educational institutions on the college and university level could do much in implementing retirement planning programs for the benefit of small business and for the public at large. Several colleges and universities have done this quite successfully. Many of the present retirement planning programs have been directed mainly at the middle and upper class income levels. Unfortunately, this procedure does not take to the low income and poverty level

individuals education and counseling that they need. And, indeed, this group of individuals need this type of counseling most.

Presently—in my area, at least—some of the charitable institutions and assistance agencies have instituted counseling to the poor and poverty level groups to help them better apply their resources to the needs of themselves and their families.

I believe it is in reason to calculate that well designed and properly implemented retirement planning programs in preretirement can be less costly in prevention than the cure through community, charity, and Government agency action. And this is to say nothing about the loss of independence, self-respect and dignity for those who find themselves needing help.

I believe that over the past several years, there has been a tendency to underestimate the resources necessary to maintain a given lifestyle in later years. In the interest of economics, I would like to review some of the factors.

Housing. According to recent published information, housing consumes 38 percent of the average gross income. Many older persons find their housing costs to be even more than this percentage. Aside from a few exceptions, the percentage of retired persons' resources consumed for housing is greater now than it was in preretirement. Contrary to popular opinion, many older persons do not own their house. They rent. It is universal knowledge that high interest rates has been a major factor in discouraging the building of housing units. This has resulted in existing properties having a high escalation in value and caused exchanges, consolidations, and conversion.

While this process has been a bonanza to many, it has been devastating to quite a large number. There has been a great number of housing conversions to condominiums, and coops, resulting in the displacement of many older persons, some to less convenient and desirable locations and many poor and poverty stricken left with no place to go.

I would like to touch on health. Health is most important. We all know that without health, one cannot live an enjoyable life, even before or after retirement. Food is one of the main factors in maintaining good health. A well-balanced, nutritious diet will maintain good health. Higher food costs have caused great inroads on older persons with fixed incomes. Indeed, in my experiences, I have known older persons who have the desire for some of the niceties or even, from necessity, have cut back on some of their food expenditures. And in every case, I have observed that these persons have deteriorated rapidly, particularly in mental capabilities.

Medical costs have increased at a higher rate over the last decade. Presently, for a couple on social security with part B medicare deductions and supplemental tie-in insurance will cost that couple $100 a month. Up to the present time, this covers hospital expenses quite completely. But in the case of physicians, in view of the medicare reasonable charge factor, patients can be faced with 20 to 25 percent additional out-of-pocket costs.

Transportation is another important factor for older persons. Even though transportation is less after retirement, it is still a must for older persons. We all realize that the cost of buying and maintaining an automobile is twice as much as it was 10 years ago.

And if a person happens to be in a position that they have to retain their old model automobile, I know from personal experience that it costs as much as $100 a month to keep it up. And this, in many instances, not satisfactory.

Public transportation is often not available, not convenient and low income people can't afford taxis and they are inconvenient also.

Items of clothing, entertainment, and other miscellaneous items have not increased in the last several years in proportion to some of the more necessary items. This is partly because you can cut them back or you can eliminate them entirely.

The fixed-income situation for most older persons, even with CPI adjustments, have not kept pace with inflationary costs and the contention that we have cured inflation has little affect on fixed-income individuals.

The potential increase in the population of older Americans makes it even more important that well designed and complete preretirement programs be available on a universal basis, not just here and there. I say this from experience, all older persons want the opportunity to maintain their independence, retain their self respect, live in dignity, and make a meaningful contribution to our social, economic, and political society.

Thank you.

Mr. DAUB. Mr. Terrel, I really did appreciate your testimony. It is thoughtful and well considered.

Congressman Skelton will be back in just a moment. He had to take care of a business matter. In the interest of time, I'm going to ask you a couple of questions. I want to give you this set of four questions the staff has prepared and ask if you would take a minute to jot us a note with your answers. We will see to it that those answers are included at this point in the record with your testimony and my questions.

[Answers not received at time of publication.]

Mr. DAUB. If inflation were continuing at the rate of 1979, 1980, and 1981, which was in the range of 12 percent, would you not agree that that would have a very disasterous impact on that person who is on fixed income? Prescription drugs doubling, you know, the cost of gas, and electricity, and telephone service, those kinds of things that are really lifeline.

Mr. TERREL. There is no question about it, particularly in the light of adequate instructions and preretirement planning for older persons. There are three stages of life: one, when you're getting ready for the working years, when you're working on a job and during those working years you need to prepare for the later years and preparing for the later years and retirement planning is an on-going thing. It's not one program here and now only. It's today, tomorrow, and the next day, even after retirement.

Mr. DAUB. In your work in the separate Action for Independent Maturity program of the Association of Retired Persons, do you get involved in the subject of older Americans buying too many life insurance policies because they are scared, causing them to pay premiums because of every newspaper and TV ad that comes along, eventually ending up with 7, 8, 9, or 10 policies? Is this a part of your work as you try to get people to understand that a lot of those

policies have coinsurance provisions that are not going to allow then to get paid twice?

Mr. TERREL. In our programs, we attempt to point out to persons in preparing for their later years that they buy only what insurance they need, not buy the extravagant policy and listen to sales promotions about what they don't need.

Mr. DAUB. I appreciate your testimony and I want to give you these and ask if you would take some time to let us have the benefit of your thinking on behalf of the people you represent so that it is in the record.

Thank you for coming today and contributing to Congressman Skelton's record.

Staff may have a question.

Mr. ARYE. I have a comment rather than a question. I would like to thank the Action for Independent Maturity in helping us compile "A Guide For Planning Retirement Finances," and I look foward to working with them in updating the guide.

Mr. DAUB. Let me note, we have a copy of that, too. If anyone is interested, this guidebook prepared by Action for Independent Maturity Division of Association of Retired Persons was prepared for the Subcommittee on Retirement Income.

Mr. SKELTON. Our next witness is Mr. Duane Dauner, president of the Missouri Hospital Association.

STATEMENT OF C. DUANE DAUNER, PRESIDENT, MISSOURI HOSPITAL ASSOCIATION

Mr. DAUNER. Thank you, Congressman Skelton and Congressman Daub.

I have the statement, which is in notebook form, and I will briefly summarize just a few points there. Missouri and Nebraska rank fifth and seventh in the country in percentage of people past 65, and that presents immediate problems for us, not only in health care but in serving the aging population. It has already been pointed out that health-care expenditures go up dramatically for the aging population and that certainly is true. We have seen and previous testifiers alluded to social costs that sometimes get transferred into the health-care sector because of changing values in our society.

On page 3 of the notebook statement, we have outlined a model of continuum care and even though I work in the acute sector, we believe that it is extremely important to see that health care is provided in a total continuum. That is, from acute, to long term, to alternatives. We feel that as the aged population increases, there must be incentives and alternatives available for the aged so that we don't end up relying on horizontal care but can concentrate on vertical care.

Mr. SKELTON. I hope you don't mind my interrupting you. I have heard the criticism that we in Congress tend to skew our help toward a nursing home type of recipient, as opposed to the acute-care type of recipient. I've heard that criticism. I'm not sure it's right. Is that correct or is that wrong, as to the number of programs over the years that Congress has passed?

Mr. DAUNER. I am not sure I would agree with that criticism. I think that Congress has dealt with the crises as they have arisen and with the passage of medicare, the philosophy has changed.

Mr. DAUB. Let me state his question a little differently. It's a very important point because this is how we try to focus what we do in our limited time with such a range of issues before us.

Does the transfer payment system of medicare/medicaid tend to pay for more expensive care more quickly than it does for home health, hospice, respite care, and things that if they don't cut costs, might tend to be more wholesome and more useful as our society ages? Do you think we put too much emphasis on paying for the expensive highcost items, for example, the heart and lung machine, the kidney transplant, the pacemakers? Is this a part of your thinking at all?

Mr. DAUNER. Yes; I think that putting that in context in the total spectrum of the aged and the health care that we have responded, beginning with medicare, to certain phases of illness to the exclusion of the slighting of others and in our business we said we should look at the total picture with emphasis on some of these other alternatives, which are less expensive and may, in fact, keep people from ending up in those more expensive modalities of treatment.

Mr. SKELTON. All right, Mr. Dauner, give us a for instance. I'm going to speed you up here, but I think we might be able to get those answers.

Mr. DAUNER. Hospice care, which would be less expensive and more highly technicologically intensive——

Mr. SKELTON. People in the audience may not know what hospice is so you'd better explain that.

Mr. DAUNER. The concept being that there are ways to treat people in a somewhat terminal phase less expensively but with dignity and respect for their lives so that we can maximize the quality of life but not apply these highest levels of technology that are available in society to apply them on a day-to-day basis for those people. That's one phase. Another is home health or day care. We have listed a number here, respite care, all of these things will help provide services to the aged without putting them in a horizontal setting. Because once they go into a nursing home or hospital, that's a different set of living circumstances and we don't want that to end up being the norm but the exception where they can lead productive lives independently of the day-to-day support of an institution.

I believe as society changes and the emphasis in our society change, the trend will lead us toward more independence—and the previous speaker spoke about the age of interest in remaining independent as long as practical and we certainly support that and believe that society is moving in that direction. And if Congress can encourage that with tax incentives, with tax reform, both for the under-65 people that may end up being family members, as well as the over 65's.

Mr. SKELTON. Go right ahead.

Mr. DAUNER. On page 4, I've outlined four reasons why we have the medicare situation costwise and that's because of the tremendous growth in our population, life expectancy is now 73. It was 68

when medicare was passed. The demand has increased dramatically and technology——

Mr. SKELTON. What do you see in the future? Has your association done some prognosis on the future as to where we may be 10, 15, 20 years from now?

Mr. DAUNER. If we continue the emphasis on technology and high-intensity service, we think that the cost will be substantially higher than 10 percent of the gross national product. We believe that that's not going to fit in with the trend and the priorities of this country.

Mr. DAUB. It reached that for the first time this year.

Mr. DAUNER. Yes.

Mr. SKELTON. So where do we go? What's your recommendation?

Mr. DAUNER. Our recommendation is that emphasis be placed on preretirement, as well as on services that will not produce the high deployment of moneys to the high-intensity services. Now, there have to be alternatives for people as opposed to replacement. The high-intensity, high-technology services will still be needed by people. The key is to make sure that we prevent those wherever possible and that we move people out of that system as rapidly as possible, and that there need to be incentives for people to search for those, under 65 as well as over 65, and that can be done in Tax Code as well as other aspects of the economy.

Health care is rationed to the extent that technology is available, historically, but we're getting to the point now that there is so much technology available, high-cost technology, that we have to look at these other alternatives and hospice is a good example of that.

Swing beds is another one and as the Congressman from Missouri knows, the Missouri Hospital Association has received a grant to help in rural communities get people out of acute beds into the swing bed and then back into productive living.

I have some recommendations from the Missouri Hospital Association on page 7 and 8 and, Congressmen, they deal with the continuum of care, the tax incentives for families, as previously mentioned, providing incentives for third-party payers, as well as private health care. We support changing incentives for the providers of health care services. We believe that substantial changes have been made that are constructive in medicare and medicaid. We think that those need to be expanded to the other health-care providers and to the elderly that need that price sensitivity, as well, so that we will all work toward reducing the demand on high-technological aspects.

On page 8, we think that demonstration projects with incentives both in medicare and medicaid are important and the Missouri medicaid program is making strides in that regard.

Finally, the last recommendation deals with options for those that are prior to retirement and the aged. Tax reform that would allow them to invest to cover future medical expenses, incentives that will help them plan in advance. My parents are past 65, my mother had emergency surgery last month in a Topeka, Kans., hospital, and as I was visiting with her, it's that unknown and even though she has medicare, she's always concerned about health care costs and if we can help people plan for that through tax reform

and investment credits, there may be a good way to avoid the crisis that people end up facing. Lifestyle has been mentioned but more than half of our health care costs are due to lifestyles of people. And that has to happen before we reach 65 and the educational process must begin in grade school and work up through preretirement so that we will not rely solely on the system to bail us out.

Mr. SKELTON. Let me ask you this: The administration has proposed freezing physician fees for medicare. Do you believe this proposal would stop doctors from taking medicare assignments?

Mr. DAUNER. Slightly more than half the physicians currently take assignments. I suspect that freezing medicare fees to physicians would reduce the number that would accept assignment. I believe further, though, that physicians, for the most part, will continue to see the older people that need medical care. I know that puts pressure on the older person and there may be a compromise way of resolving that. I am disappointed that the large number of physicians that exist that do not take assignments. However, I can appreciate their view.

Mr. SKELTON. What's the reason they don't, in your opinion? You talk with a lot of them. What is the reason they don't?

Mr. DAUNER. I think there are two reasons: No. 1, they believe that the amount that the Government pays is insufficient for their service and, No. 2, a lot of the physicians are finding that the paperwork and the regulations, when they file the claim correctly, are more than they want to cope with. It transfers that responsibility to the aged person when they don't accept assignment because then they bill the patient and the patient has to recover the money from medicare and is responsible for the total bill.

Mr. SKELTON. At this point, I want the record to reflect that without objection that the written testimony of each of the witnesses in full will be set forth in the record, in addition to the oral testimony and, Mr. Reporter, I would hope that you would make such a memorandum for your files.

[The prepared statement of Mr. Dauner, along with the prepared statement of the Missouri Hospital Association, follow:]

PREPARED STATEMENT OF C. DUANE DAUNER, PRESIDENT, MISSOURI HOSPITAL ASSOCIATION

INTRODUCTION

Mr. Chairman and members of the Select Committee on Aging, I am C. Duane Dauner, president of the Missouri Hospital Association (MHA). I am pleased to speak before you today on the economics of aging.

Problems of the elderly are overlooked by many of us, at least until we face the issue directly or with relatives and friends. Health care presents unique demands on the elderly and providers of health care services. My presentation will address several of these issues.

The aging or "graying" of the population has become a matter of major concern, both nationally and in the state of Missouri. In a nation where the number of persons 65 years of age and older approaches 11 percent, Missouri's elderly population exceeds 13 percent. As such, Missouri ranks fifth in the nation in the percent of total population over 65, following Florida, Rhode Island, Arkansas and Iowa (see Exhibit 1). Today, there are approximately 26 million people over age 65 in the nation; this figure is expected to double by the year 2030. In Missouri, the 65-and-over population grew 15.6 percent during the past decade, while the total population grew only 5.1 percent (see Exhibits 2 and 3).

Since 1940, the number of older Missourians has grown five times as fast as the number of wage earners, age 20–64, and the 75-plus age group and the number of

older women in the state are growing even faster than the over-65 population as a whole. Over the next 40 years, Missouri's 65-plus population is expected to increase by another 40 percent. Much of Missouri's high proportion of elderly may be attributed to the out-migration of young people over the past four decades and the recent influx of retirees, particularly in the southern part of the state.

Nationwide, this growing number of aged persons is requiring a reevaluation of the kinds and numbers of health care services and financing systems that have been available traditionally. In the past, health care systems have focused upon horizontally-oriented acute care and long-term care services for the elderly. However, according to the Missouri Division of Aging, most older Missourians are relatively unimpaired by the aging process and require little or no care from others. Approximately 18 percent of Missouri's older citizens are considered seriously impaired while 43 percent are considered mildly impaired in the daily activities of living. Only one in every three seriously impaired older Missourians receives care in a nursing home (see Exhibit 4). Most seriously impaired elderly continue to live in the community with care provided by family and friends. Only recently have health care program begun to provide alternative care services as a benefit—the focus is moving away from more costly institutional care (see Exhibit 6).

THE ECONOMIC REALITY OF AGING

The lack of appropriate financing systems for a continuum of care system may be somewhat due to a misconception that most elderly people have limited spending power (with the exception of health care services) and less inclination to spend. According to Nation's Business (April 1981), the elderly are not a categorically poverty group. The real economic power of the 55-plus market accounts for: (1) 30 percent of total U.S. personal incomes; (2) nearly 80 percent of all money in savings and loan institutions; (3) an estimated 28 percent of all discretionary money in the U.S. consumer marketplace—nearly double that of households held by persons 34 years of age or under. The real surprise is that most persons 65 and older are not poor.

The poverty rate in this group is slightly more than that of the population at large—15 percent. More than 70 percent of the 65-plus population own their own homes, many mortgage-free. Per-capita income of households held by someone 65 and over is $500 less than the population as a whole (See Exhibit 7). Annual per-capita income of older families exceed all other age groups except those in the prime middle years, the 55-to-64-year-olds.

The health care spending habits of the 55-plus consumer households have long been known, accounting for nearly $4.00 of every $10.00 in the marketplace; less reported is this group's consumption of other products (see Exhibit 8). For example, households headed by 55-plus consumers acount for: (1) $1.00 of every $4.00 for cosmetics and bath products; (2) $4.00 overy $10.00 spent on women's hair care services and beauty parlors; (3) $3.00 of every $10.00 spent on food consumed in the home (40 percent of all coffee purchases alone); and (4) $1.00 of every $4.00 spent for alcoholic beverages, including one third of all purchases of hard liquor (Nation's Business, April 1981)

Because expenditures for health care increase geometrically with age after people reach 65, the financial burden becomes distorted. A small minority of aged persons consume the bulk of the expensive health care services. For the aged who able to pay for their care, most of their expenses are covered by Medicare and private supplemental insurance. For the persons unable to pay, Medicare and either private insurance or Medicaid cover most of the services used.

The philosophy that institutional care is covered by government tends to encourage high utilization and high-option care. Unless normal economic forces play some role in patient demands, utilization and cost will continue to rise.

THE CONTINUUM OF CARE SYSTEM

In recent years, attention has been placed upon the development of a continuum of care system for the elderly which would address each person's need in the least restrictive and most cost-effective setting. The continuum of care would provide an entire range of alternative services for the elderly that would include acute care services, long-term care services, and certain specific "substitute," not add-on, alternative care services (hospice, respite, adult day care, ambulatory care, home health care, etc.) (see Exhibit 9). The development of this medical care model system must be teamed with home and community-based services in order to offer a more comprehensive, cost-effective, efficient and accessible system of care. A description of a "model" continuum of care system, and current financing mechanisms, is listed below:

Type of services	Benefit coverage
Acute care services: inpatient/outpatient; rehabilitation; ancillaries.	Limited to persons enrolled in medicare or medicaid programs, or through third-party payers and private/self-pay.
Long-term care services:	
Skilled nursing (SNF)	Limited to persons enrolled in medicare or medicaid programs, or through third-party payers and self-pay. Three-day prior hospitalization for medicare beneficiaries; subject to utilization review. Hospital-based facilities paid separate rate. Private/self-pay.
Intermediate care (ICF)	Limited to persons enrolled in the medicaid program, some third-party payers and private/self pay. Few incentives for comprehensive non-skilled therapies.
Custodial care services: residential care; boarding home care	Limited to persons enrolled in the medicaid program and private/self-pay.
Swing-bed services: skilled nursing; intermediate care nursing	Limited to small, rural hospitals of 49 beds or less for persons enrolled in the medicare or medicaid programs and third-party payers. Skilled care limited by medicare SNF "conditions of participation," three-day prior hospitalization; and limited number of available covered days. ICF permitted under title XIX, but low per diems discourage provider participation.
Home Health Care Services: home health; day care; respite care	Limited to persons enrolled in the medicare or medicaid programs, third-party payers (limited number covered visits/services), and private self-pay.
Hospice	Limited to persons enrolled in medicare/Blue Cross or third-party payers. No funding available for Missouri medicaid in fiscal year 1984. Regulations and reimbursement proposed in the August 22, 1983, Federal Register limit entry by providers and access by the terminally ill.
Rehabilitative services	Limited to persons enrolled in the medicare and medicaid programs, third-party payers and self-pay. Subject to medically necessary authorizations and certification of approved rehabilitation providers.
Alternative community-based services: Congregate housing; meals; transportation; protective services; counseling and emergency services; personal care homemaker/chore services; case management.	Federal block grants for community-based providers provide limited access to these services for medically and financially indigent. Limited to persons enrolled in the Missouri medicaid program, through federally waived long-term care channeling demonstration project, and private/self-pay.

THE FINANCING SYSTEMS—PAST AND FUTURE

Financing of health care services for the elderly has been limited primarily to acute and long-term care services through the Medicare program, Medicaid, state programs and private insurers (see Exhibits 10 and 11). In 1966 when the Medicare program was implemented, the federal government paid hospitals their costs of providing care to Medicare patients, but the architects underestimated four things: 1) the growth in our elderly population (resulting from more people reaching age 65, longer life expectancy and new technology); 2) the tremendous "demand" that would result from offering "free" health care services; 3) geometric growth in technology; and 4) inflation (see Exhibit 12).

It is important to note that 70 percent of Medicare payments to hospitals cover services rendered to elderly beneficiaries during the last year of life. Fifteen percent of all Medicare payments to hospitals are for care given during the last two weeks of life (see Exhibit 13). The cost of dying and use of high-cost technology are major issues which must also be addressed as the age population grows.

Historically, medical care was rationed by the extent to which technology was available. The explosion of new technology and knowledge, which has successfully lengthened life, is forcing a widening gap between the expectations of individuals and the limitation on the financial resources available. Per-capita health care costs for 1982 reveal tremendous differences between people age 45–65 and those over age 65 (see Exhibit 14). The annual per-capita health care costs are $837.00 and $3,336.00 respectively for the two age groups.

Today, the elderly think their hospital bills are paid entirely by Medicare. The truth is that Medicare pays hospitals approximately 80 percent of the cost of caring

for these patients. The Medicaid program, which also reimburses providers at less than cost for acute care and long-term care services, has faced increased demands for limited state financial resources. In fiscal year 1982, state and federal funds provided nursing home care for approximately 28,270 older Missourians, at a cost to the Medicaid program of $142,666,000. In fiscal year 1982, nursing home care accounted for 89 percent of all public spending for long-term care for older Missourians. Overall, more than 70 percent of all nursing home patients are covered by Medicaid and state programs.

Nursing home expenditures have diverted funds away from alternative care services that often are most cost-effective. The Division of Aging estimates that 16–38 percent of all nursing home applicants can be cared for more cost-effectively at home. In fiscal year 1982, the average per-client Medicaid expenditure for nursing home care in Missouri was more than twice the cost of the equivalent home services ($805.00 and $368.00 respectively).

While meeting the need for hospital and nursing home-based services, both Medicare and Medicaid have only recently expanded eligibility and benefit coverage to the "alternative care system" on a limited scale. Home health care and hospice are covered benefits for Medicare and Medicaid eligibles, with the hospice benefit becoming effective November 1, 1983. However, these services are restricted by the number of visits per eligible, the payment rate for services rendered, and the types of individuals who qualify for the services; and they are becoming more regulated by federal and state agencies.

In 1980, Congress enacted Section 904 of the Omnibus Budget Reconciliation Act to provide for "swing-bed" programs in rural hospitals. The "swing-bed" concept allows a rural hospital of 49 or fewer beds to utilize existing acute care beds for long-term care services to Medicare, Medicaid, privately insured and self-pay patients on a limited basis. While reimbursement is limited to the state's average SNF per diem for the prior calendar year, the "swing-bed" concept allows small or rural hospitals to provide needed long-term care services and utilize existing bed capacity in a more optimal fashion; the latter enhances the financial stability of the institutions. In Missouri, eligible hospitals are limited to $45.18 for SNF patients and $30.98 for ICF patients.

In 1981, the Missouri Hospital Association was one of five state hospital associations to be awarded grants from the Robert Wood Johnson Foundation to develop the "swing-bed" concept in eligible hospitals over a four-year period. If it was not limited by law to small or rural hospitals, the "swing-bed" concept would provide an opportunity for all hospitals to optimize their existing bed capacity and facility resources at a fraction of the cost for newly constructed nursing homes. MHA currently is providing technical assistance to 23 eligible small or rural hospitals and will submit an application on behalf of all large and urban hospitals for financial aid from the Foundation later this year. We urge this Committee to support expansion of the "swing-bed" concept and other innovative demonstration projects to all hospitals, regardless of size or location.

Several major trends will influence the direction of health care for the elderly during the remainder of this decade (see Exhibits 15 through 17):

the need for long-term solutions to replace short-sighted, short-term expendiences;
greater emphasis on self-reliance by the elderly and their families;
growing importance of multiple options and choices to individuals;
the increasing number of aged Americans;
convenience care and non-institutional care;
reduction in institutional capacity;
retrenchment in payment incentives for horizontal care;
home care, ambulatory care and outreach services;
information systems available to individuals;
gatekeeper case management (whereby one provider manages the total care of a patient, receives total payment for the patient and determines what portion of that payment will go to all others involved);
competing financing and delivery systems;
corporate restructuring of providers, diversification and vertical integration of delivery systems;
growing number of physicians and health personnel; and
jurisdictional disputes among health care professionals.

Trends such as these call for a basic shift in philosophy. James Schulz, author of *The Economics of Aging*, notes that "the significant, semi-hidden story in the federal budget is that America's public resources are increasingly being mortgaged for the use of a single group within our country, the elderly." We must recognize that it is impossible to provide to all people the highest level of care that is technically possi-

ble. A sense of appreciation for limits must evolve. Individuals must become involved in decisions which influence their health care (see Exhibits 18 and 19). Alternatives in health care delivery and health care financing must move in the direction of major societal trends. Several alternatives have been proposed which are compatible with our society of the future. They include:

choice of competitive health care plans for the elderly covering a defined level of benefits;

latitude for providers to offer selective services to publicly-sponsored patients;

greater individual responsibility in selecting health care providers;

out-of-pocket financial participation by the elderly at the time service is demanded;

prepaid systems which introduce price sensitivity and place insureds, providers and third parties at risk;

individualized case management programs; and

competitive delivery and financing systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

MHA RECOMMENDATIONS

The U.S. Congress can assist in promoting long-term effective utilization (and cost) of health care services for the elderly. Some possible actions include:

developing tax incentives for families to assume responsibilities for elderly relatives and for Medicaid beneficiaries;

appropriating adequate funds, administered through appropriate marketplace and incentive programs, for expansion of substitute services to the elderly and publicly-sponsored recipients, including Medicare, Medicaid, swing-beds, hospice, home care and adult day care;

developing incentives for providers and third-party payers to offer low-option care and less costly substitute care as alternatives to high-option/high-intensity services;

revising medical professional liability laws to keep the frequency and severity of claims at a reasonable level;

requiring Medicare and insurance companies to furnish insureds data which will increase their level of sensitivity to prices of services they demand;

eliminating barriers to alternative care and marketplace systems, including:

elimination of the 49-bed ceiling for swing-bed hospital programs,

elimination of Medicare cost allocation process for hospital-based long-term care facilities,

elimination of the number of days or visits under certain Title XVIII and Title XIX covered services (limits on visits by certified home health agencies and on days of skilled care provided in certified nursing homes, etc.), and

requirement that insurance plans provide for alternative care services and include cost-sharing provisions (copayments and deductibles) with upper limits for catastrophic coverage (cost sharing amounts could be tied to individual or family income for greater equity);

developing model demonstration programs for a continuum of care system for the elderly, including capitation, prepaid health and lock-in programs for Medicare and Medicaid beneficiaries (provide federal and state financial assistance for development and implementation of "modeling" systems);

eliminating reimbursement and legal barriers for hospital-based hospices until 1986 and requiring the Secretary of the Department of Health and Human Services to study the hospice program in anticipation of a prospective payment system for hospice care;

providing financial incentives to health care providers who care for the heavy-care/total-care patient to recognize differing levels of long-term care; and

offering options to the aged (including those approaching Medicare eligibility status) to invest in insurance and estate planning programs, allowing people to purchase insurance or annuities to cover future medical expenses, with any net proceeds accruing to his or her estate (such a plan could be supported by tax credits and increased deductions).

The above alternatives are not exhaustive. They represent ideas which can change the incentives for all parties on both the demand and the supply sides of the health care equation. Competition, marketplace incentives and individual initiatives/responsibilities are basic to America and democracy. Efforts to change emphasis in health care will be more successful if they take into account these principles.

SUMMARY

Rising health care costs are being addressed with more intensity than ever before. The new Medicare prospective payment system which will pay hospitals a pre-set rate, depending on the diagnosis, and private sector initiatives are changing the incentives for providers and patients. The development of preferred provider organizations and health maintenance organizations in Missouri is evidence of marketplace competitive factors as the health care industry enters this transitional phase.

Change already is evident in many areas where health care providers are competing on the basis of price as well as services offered. MHA supports competition and marketplace incentives and is willing to assist in any way that we can to improve the delivery of health care in a cost-effective manner.

We congratulate the Select Committee on Aging for its interest in the economics of aging. We thank you for the opportunity to share our perspectives on the provision of health care for the elderly, and we pledge our support in developing solutions to the problems which challenge our aging society.

Thank you for the opportunity to present this statement.

PREPARED STATEMENT OF THE MISSOURI HOSPITAL ASSOCIATION

INTRODUCTION

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sumer marketplace—nearly double that of households held by persons 34 years of age or under. The real surprise is that most persons 65 and older are not poor.

The poverty rate in this group is slightly more than that of the population at large—15 percent. More than 70 percent of the 65-plus population own their own homes, many mortgage-free. Per-capita income of households held by someone 65 and over is $500 less than the population as a whole (see Exhibit 7). Annual per-capita income of older families exceed all other age groups except those in the prime middle years, the 55-to-64-year-olds.

The health care spending habits of the 55-plus consumer households have long been known, accounting for nearly $4.00 of every $10.00 in the marketplace; less reported is this group's consumption of other products (see Exhibit 8). For example, households headed by 55-plus consumers account for: (1) $1.00 of every $4.00 for cosmetics and bath products; (2) $4.00 of every $10.00 spent of on women's hair care services and beauty parlors; (3) $3.00 of every $10.00 spent on food consumed in the home (40 percent of all coffee purchases alone); and (4) $1.00 of every $4.00 spent for alcoholic beverages, including one third of all purchases of hard liquor. (Nation's Business, April 1981)

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In recent years, attention has been placed upon the development of a continuum of care system for the elderly which would address each person's need in the least restrictive and most cost-effective setting. The continuum of care would provide an entire range of alternative services for the elderly that would include acute care services, long-term care services, and certain specific "substitute," not add-on, alternative care services (hospital, respite, adult day care, ambulatory care, home health care, etc.) (see Exhibit 9). The development of this medical care model system must be teamed with home and community-based services in order to offer a more comprehensive, cost-effective, efficient and accessible system of care. I description of a "model" continuum of care system is listed below:

TYPE OF SERVICES

Acute Care Services: inpatient/outpatient; rehabilitation; ancillary services.
Long-Term Care Services: skilled nursing (SNF); intermediate care (ICF).
Custodial Care Services: residential care; boarding home care.
Swing-Bed Services: skilled nursing; intermediate care nursing.
Home Health Care Services: home health; day care; respite care.
Hospice.
Rehabilitation Services.
Alternative Community-Based Services: Congregate Housing; Meals; Transportation; Protective Services; Counseling and Emergency Services; Personal Care/Homemaker/Chore Services; Case Management.

Integrated, cost-effective financing systems should be provided through the public and private sectors for government-sponsored and privately-sponsored patients respectively. Currently, unsponsored individuals should become the responsibility of government or the private sector, depending on their status. In either event, the patients should be influenced by marketplace forces to the degree their economic status permits.

THE FINANCING SYSTEMS—PAST AND FUTURE

Financing of health care services for the elderly has been limited primarily to acute and long-term care services through the Medicare program, Medicaid, state programs and private insurers (see Exhibits 10 and 11). In 1966 when the Medicare program was implemented, the federal government paid hospitals their cost of providing care to Medicare patients, but the architects underestimated four things: 1) the growth in our elderly population (resulting from more people reaching age 65, longer life expectancy and new technology); 2) the tremendous "demand" that would

result from offering "free" health care services; 3) geometric growth in technology; and 4) inflation (See Exhibit 12).

It is important to note that 70 percent of Medicare payments to hospitals cover services rendered to elderly beneficiaries during the last year of life. Fifteen percent of all Medicare payments to hospitals are for care given during the last two weeks of life (see Exhibit 13). The cost of dying and use of high-cost technology are major issues which must also be addressed as the aged population grows.

Historically, medical care was rationed by the extent to which technology was available. The explosion of new technology and knowledge, which has successfully lengthened life, is forcing a widening gap between the expectations of individuals and the limitation on the financial resources available. Per-capita health care costs for 1982 reveal tremendous differences between people age 45–65 and those over age 65 (see Exhibit 14). The annual per-capita health care costs are $837.00 and $3,336.00 respectively for the two age groups.

Since 1965 when the Medicare law was enacted, government overpromises and expanded benefits have led the aged to expect the best of all services available—at public expense. In recent years, however, government has cut back on payments to providers as an expedient way to reduce overall federal budget deficits. Congressional policies are being driven by budgetary pressures with little regard for the implications of arbitrary cutbacks in payments to hospitals and other providers.

With the enactment of the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) and the Social Security Amendments of 1983 (SSA of 1983), Congress reduced payments to hospitals and changed the economic incentives pertaining to acute institutional care. Overlooked in TEFRA and the SSA of 1983 are patients and other providers. Alone, hospitals cannot change the system nor can hospitals modify the expectations and behavior of Medicare beneficiaries.

In 1982, Medicare and Medicaid paid Missouri hospitals $250 million less than the actual cost of caring for Title XVIII and Title XIX patients. These "contractual allowances" create tremendous burdens on hospitals, particularly rural institutions in Missouri having a hign proportion of Medicare patients and certain other hospitals that treat a large share of the Medicaid population.

Today, the elderly think their hospital bills are paid entirely by Medicare. The truth is that Medicare pays hospitals approximately 80 percent of the cost of caring for these patients. The Medicaid program, which also reimburses providers at less than cost for acute care and long-term care services, has faced increased demands for limited state financial resources. In fiscal year (fiscal year) 1982, state and federal funds provided nursing home care for approximately 28,270 older Missourians, at a cost to the Medicaid program of $142,666,000. In fiscal year 1982, nursing home care accounted for 89 percent of all public spending for long-term care for older Missourians. Overall, more than 70 percent of all nursing home patients are covered by Medicaid and state programs.

Nursing home expenditures have diverted funds away from alternative care services that often are more cost-effective. The Division of Aging estimates that 16–38 percent of all nursing home applicants can be cared for more cost-effectively at home. In fiscal year 1982, the average per-client Medicaid expenditure for nursing home care in Missouri was more than twice the cost of the equivalent home services ($805.00 and $368.00 respectively).

While meeting the need for hospital and nursing home-based services, both Medicare and Medicaid have only recently expanded eligibility and benefit coverage to the "alternative care system" on a limited scale. Home health care and hospice are covered benefits for Medicare and Medicaid eligibles, with the hospice benefit becoming effective November 1, 1983. However, these services are restricted by the number of visits per eligible, the payment rate for services' rendered, and the types of individuals who qualify for the services; and they are becoming more regulated by federal and state agencies.

In 1980, Congress enacted Section 904 of the Omnibus Budget Reconciliation Act to provide for "swing-bed" programs in rural hospitals. The "swing-bed" concept allows a rural hospital of 49 or fewer beds to utilize existing acute care beds for long-term care services to Medicare, Medicaid, privately insured and self-pay patients on a limited basis. While reimbursement is limited to the state's average SNF per diem for the prior calendar year, the "swing-bed" concept allows small or rural hospitals to provide needed long-term care services and utilize existing bed capacity in a more optimal fashion; the latter enhances the financial stability of the institutions. In Missouri, eligible hospitals are limited to $45.18 for SNF patients and $30.98 for ICF patients.

In 1981, the Missouri Hospital Association was one of five state hospital associations to be awarded grants from the Robert Wood Johnson Foundation to develop

the "swing-bed" concept in eligible hospitals over a four-year period. If it was not limited by law to small or rural hospitals, the "swing-bed" concept would provide an opportunity for all hospitals to optimize their existing bed capacity and facility resources at a fraction of the cost for newly constructed nursing homes. MHA currently is providing technical assistance to 23 eligible small or rural hospitals and will submit an application on behalf of all large and urban hospitals for financial aid from the Foundation later this year. We urge this Committee to support expansion of the "swing-bed" concept and other innovative demonstration projects to all hospitals, regardless of size or location.

Several major trends will influence the direction of health care for the elderly during the remainder of this decade (see Exhibits 15 through 17):

the need for long-term solutions to replace short-sighted, short-term expediencies;
greater emphasis on self-reliance by the elderly and their families;
growing importance of multiple options and choices to individuals;
the increasing number of aged Americans;
convenience care and non-institutional care;
reduction in institutional capacity;
retrenchment in payment incentives for horizontal care;
home care, ambulatory care and outreach services;
information systems available to individuals;
gatekeeper case management (whereby one provider manages the total care of a patient);
competing financing and delivery systems;
corporate restructuring of providers, diversification and vertical integration of delivery systems;
growing numbers of physicians and health personnel; and
jurisdictional disputes among health care professionals.

Trends such as these call for a basic shift in philosophy. James Schulz, author of The Economics of Aging, notes that "the significant, simi-hidden story in the federal budget is that America's public resources are increasingly being mortgaged for the use of a single group within our country, the elderly." We must recognize that it is impossible to provide to all people the highest level of care that is technically possible. A sense of appreciation for limits must evolve. Individuals must become involved in decisions which influence their health care (see Exhibits 18 and 19). Alternatives in health care delivery and health care financing must move in the direction of major societal trends. Several alternatives have been proposed which are compatible with our society of the future. They include:

choice of competitive health care plans for the elderly covering a defined level of benefits;
latitude for providers to offer selective services to publicly-sponsored patients;
greater individual responsibility in selecting health care providers;
out-of-pocket financial participation by the elderly at the time service is demanded;
prepaid systems which introduce price sensitivity and place insureds, providers and third parties at risk;
individualized case management programs; and
competitive delivery and financing systems such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs).

MHA RECOMMENDATIONS

The U.S. Congress can assist in promoting long-term effective utilization (and cost) of health care services for the elderly. Some possible actions include:

appropriating adequate funds, administered through appropriate marketplace and incentive programs, for expansion of substitute services to the elderly and publicly-sponsored recipients, including Medicare, Medicaid, swing-beds, hospice, home care and adult day care;
developing tax incentives for families to assume responsibilities for elderly relatives and for Medicaid beneficiaries;
developing incentives for providers and third-party payers to offer low-option care and less costly substitute care as alternatives to high-option/high-intensity services;
revising medical professional liability laws to keep the frequency and severity of claims at a reasonable level;
requiring Medicare and insurance companies to furnish insureds data which will increase their level of sensitivity to prices of services they demand;
eliminating barriers to alternative care and marketplace systems, including:
elimination of the 49-bed ceiling for swing-bed hospital programs,

elimination of Medicare cost allocation process for hospital-based long-term care facilities,

elimination of the number of days or visits under certain Title XVIII and Title XIX covered services (limits on visits by certified home health agencies and on days of skilled care provided in certified nursing homes, etc.), and

requirement that insurance plans provide for alternative care services and include cost-sharing provisions (copayments and deductibles) with upper limits for catastrophic coverage (cost sharing amounts could be tied to individual or family income for greater equity);

developing model demonstration programs for a continuum of care system for the elderly, including capitation, prepaid health and lock-in programs for Medicare and Medicaid beneficiaries (provide federal and state financial assistance for development and implementation of "modeling" systems);

eliminating reimbursement and legal barriers for hospital-based hospices until 1986 and requiring the Secretary of the Department of Health and Human Services to study the hospice program in anticipation of a prospective payment system for hospice care;

providing financial incentives to health care providers who care for the heavy-care/total-Care patient to recognize differing levels of long-term care; and

offering options to the aged (including those approaching Medicare eligibility status) to invest in insurance and estate planning programs, allowing people to purchase insurance or annuities to cover future medical expenses, with any net proceeds accruing to his or her estate (such a plan could be supported by tax credits and increased deductions).

The above alternatives are not exhaustive. They represent ideas which can change the incentives for all parties on both the demand and the supply sides of the health care equation. Competition, marketplace incentives and individual initiatives/responsibilities are basic to America and democracy. Efforts to change emphasis in health care will be more successful if they take into account these principles.

SUMMARY

Rising health care cost are being addressed with more intensity than ever before. The new Medicare prospective payment system which will pay hospitals a pre-set rate, depending on the diagnosis, and private sector initiatives are changing the incentives for providers and patients. The development of preferred provider organizations and health maintenance organizations in Missouri is evidence of marketplace competitive factors as the health care industry enters this transitional phase.

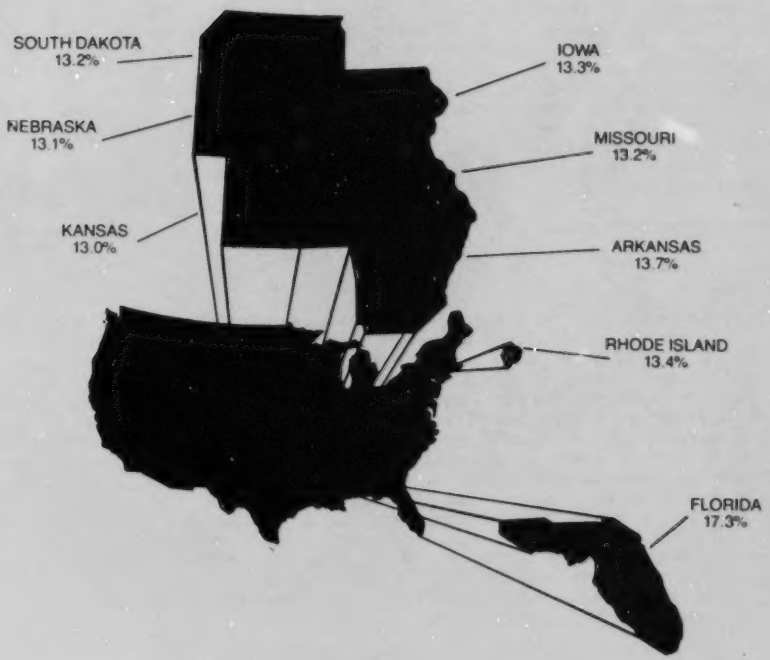
Change already is evident in many areas where health care providers are competing on the basis of price as well as services offered. MHA supports competition and marketplace incentives and is willing to assist in any way that we can to improve the delivery of health care in a cost-effective manner.

We congratulate the Select Committee on Aging for its interest in the economics of aging. We thank you for the opportunity to share our perspectives on the provision of health care for the elderly, and we pledge our support in developing solutions to the problems which challenge our aging society.

Thank you for the opportunity to present this statement.

Exhibit 1

DISTRIBUTION OF 65+ POPULATION BY STATE: 1980



Source: United States Bureau of the Census. (See References for details.)

MISSOURI'S ELDERLY

Missouri's over-age-65 population is growing faster than the population as a whole.

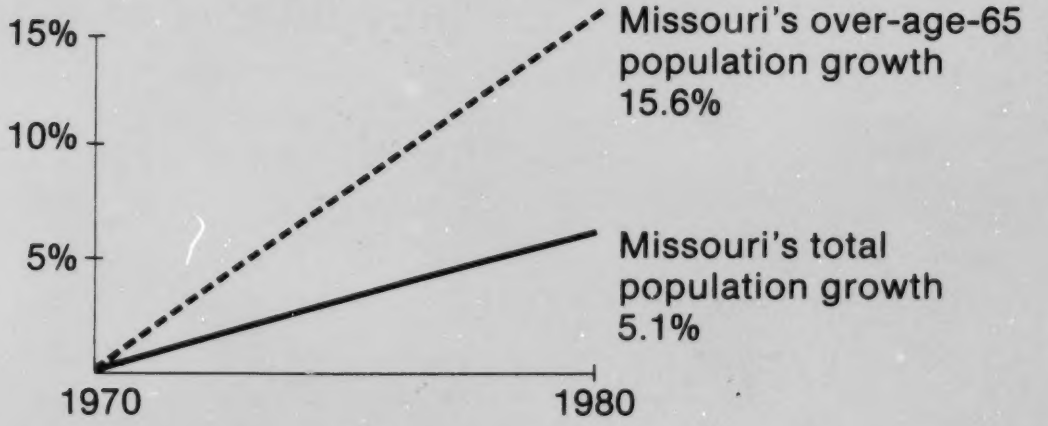


Exhibit 2

35

THE ELDERLY POPULATION

National Population, Age 65+

- 19 million in 1966
- 26 million in 1983
- 52 million by 2030

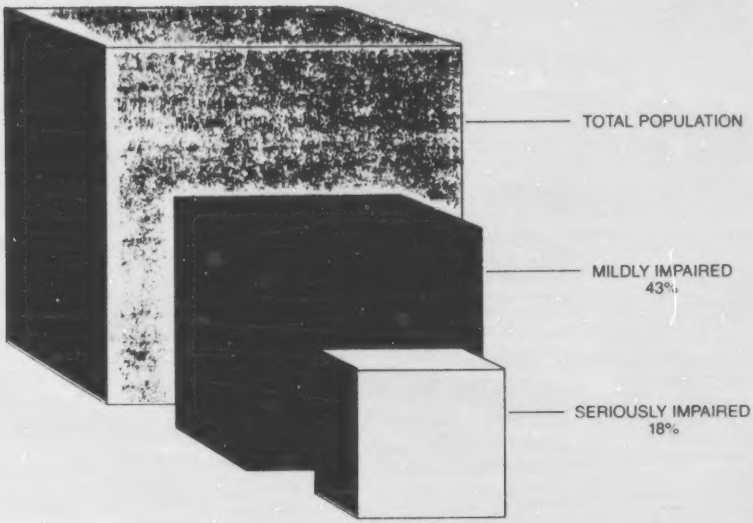
Fastest Growing Population Group

- 75+

Exhibit 3

Exhibit 4

PERCENT OF OLDER MISSOURIANS NEEDING ASSISTANCE
IN DAILY ACTIVITIES OF LIVING



Source: U.S. Bureau of Census, U.S. General Accounting Office. (See References for details.)

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Exhibit 5

Table 1. Percentages of noninstitutionalized U.S. population 65 years and over in poor health, unable to carry on major activity, and deaths per 1,000 population, 1975

Age group 65 years and over	Both sexes	Men	Women
	Percent reporting poor health [1]		
All ages, 65 and over	8.6	9.4	8.0
65–74	8.1	9.3	7.2
75 and over	9.5	9.8	9.4
	Percent unable to carry on major activity [1]		
All ages, 65 and over	17.2	29.2	8.8
65–74	14.0	25.5	5.2
75 and over	22.9	36.8	14.5
	Deaths per 1,000 total population [2]		
All ages, 65 and over	54.3	67.0	45.5
65–74	32.2	44.6	22.7
75–84	74.5	96.5	61.0
85 and over	153.1	177.0	141.4

[1] Unpublished data on the noninstitutionalized population from Health Interview Survey, National Center for Health Statistics.
[2] From Provisional Statistics, Annual Summary for the United States, 1975. Monthly Vital Statistics Report. DHEW Publication No. (HRA) 76-1120. U.S. Government Printing Office, Washington, D.C., 1976.

From: "Health of the Elderly and Use of Health Services," Public Health Reports (January - February 1977), Vol. 92, No. 1, Page 11

Exhibit 6

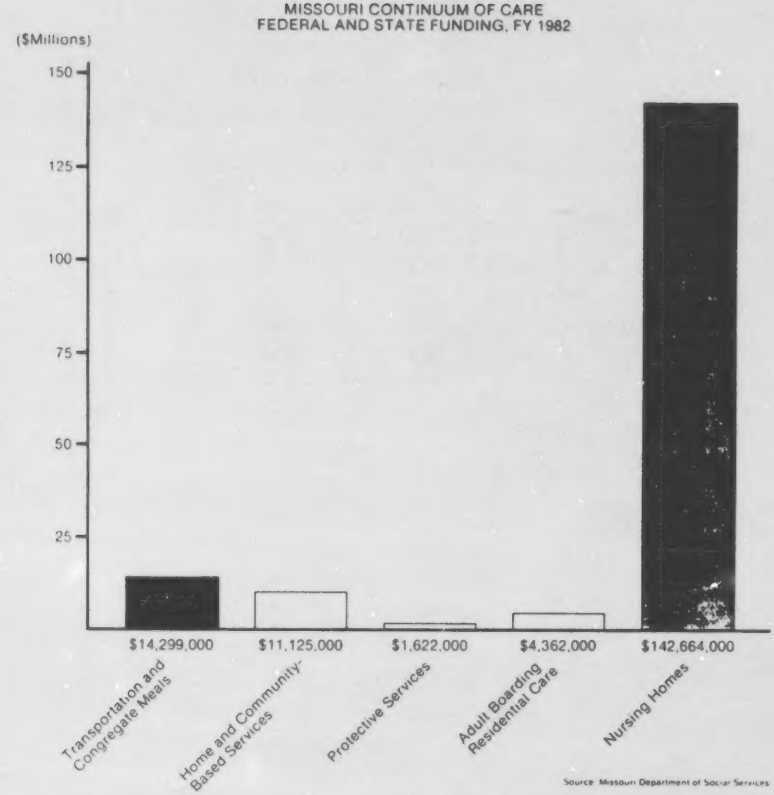
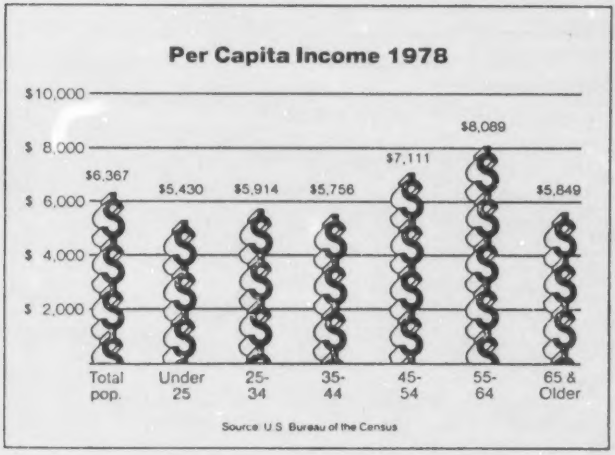

MISSOURI CONTINUUM OF CARE
FEDERAL AND STATE FUNDING, FY 1982
($Millions)
150
125
100
75
50
25
$14,299,000
$11,125,000
$1,622,000
$4,362,000
$142,664,000
Transportation and Congregate Meals
Home and Community-Based Services
Protective Services
Adult Boarding Residential Care
Nursing Homes
Source: Missouri Department of Social Services

Exhibit 7



From: "Over 55: Growth Market of the 80s," Nation's Business (April 1981)

Exhibit 8

Table 6. Estimated amount, percent distribution, and per capita personal health care expenditures for persons 65 years and over, fiscal year 1975

Type of expenditure	Total	Source of funds			
		Private	Public		
			Total	Medicare	Other
	Amount (in millions)				
Total	$30,383	$10,466	$19,917	$12,749	$7,169
Hospital care	13,467	1,379	12,088	9,719	2,369
Physicians' services	4,862	1,987	2,875	2,628	247
Dentists' services	540	502	38	0	38
Other professional services	441	220	221	167	54
Drugs and drug sundries	2,629	2,285	344	0	344
Eyeglasses and appliances	506	498	8	0	8
Nursing home care	7,650	3,571	4,079	234	3,845
Other health services	288	24	264	0	264
	Percent distribution				
Total	100.0	34.4	65.6	42.0	23.5
Hospital care	100.0	10.2	89.8	72.2	17.6
Physicians' services	100.0	40.9	59.1	54.1	5.1
Dentists' services	100.0	92.9	7.1	.0	7.1
Other professional services	100.0	49.8	50.2	38.0	12.2
Drugs and drug sundries	100.0	86.9	13.1	.0	13.1
Eyeglasses and appliances	100.0	98.4	1.6	.0	1.6
Nursing home care	100.0	46.7	53.3	3.1	50.3
Other health services	100.0	8.2	91.8	.0	91.8
	Per capita				
Total	$1,360.16	$468.53	$891.63	.....	.....
Hospital care	602.89	61.75	541.14	.....	.....
Physicians' services	217.66	88.96	128.69	.....	.....
Dentists' services	24.17	22.45	1.72	.....	.....
Other professional services	19.74	9.83	9.91	.....	.....
Drug and drug sundries	117.68	102.30	15.38	.....	.....
Eyeglasses and appliances	22.65	22.29	.36	.....	.....
Nursing home care	342.47	159.88	182.58	.....	.....
Other health services	12.89	1.05	11.84	.....	.....

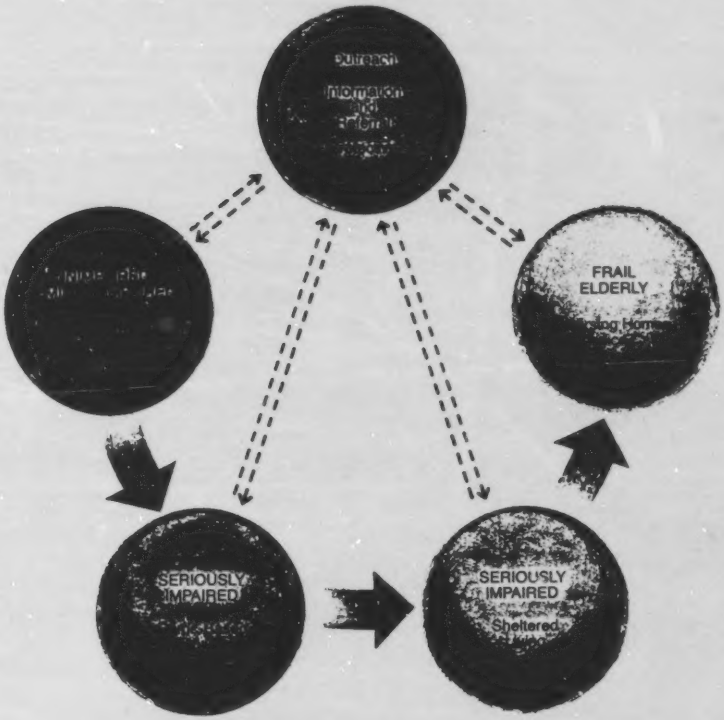
NOTE: Preliminary estimates.

SOURCE: Social Security Administration, Office of Research and Statistics. Age Differences in Health Care Spending, Fiscal Year 1975. Research and Statistics Note No. 11. DHEW Publication No. (SSA) 76-11701. U.S. Government Printing Office, Washington, D.C., 1975.

From: "Health of the Elderly and Use of Health Services," Public Health Reports (January - February 1977), Vol. 92, No. 1, Page 14

Exhibit 9

CONTINUUM OF CARE FOR THE ELDERLY



EVOLUTION IN HEALTH CARE

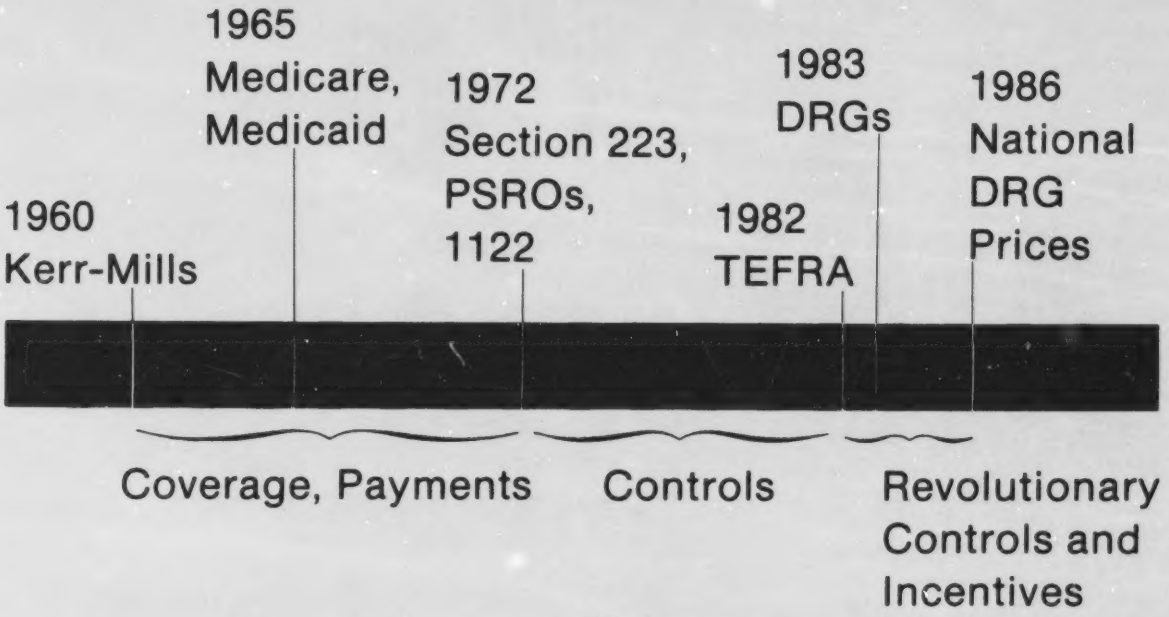


Exhibit 10

Exhibit 11

GOVERNMENT INVOLVEMENT IN CARE FOR THE AGED

Since World War II, a variety of explicit public policy enactments and events have been directed toward the issue of long-term care for the aged. A brief chronology of major executive and legislative decisions will show the extent and direction of national policy.

1948 The Federal Security Agency (predecessor to the Department of Health, Education and Welfare) set up a task force on aging.

1950 Oscar Ewing, Director of the Federal Security Agency, called the first National Conference on Aging.

1953 Federal participation in the cost of assistance paid to indigent persons in private institutions was authorized. The prohibition against payment in public institutions continued.

States seeking federal participation in the cost of payments made to persons in private institutions were required to establish standards for such institutions.

1954 The Hill-Burton Program, for the first time, was given authority for aiding, through direct grants, public and other nonprofit sponsors in constructing and equipping nursing homes and related facilities.

1958 The Small Business Administration was authorized through the Small Business Act and the Small Business Investment Act to provide loans to nursing homes.

1959 The National Housing Act was amended to provide for mortgage insurance to private lenders to facilitate construction or rehabilitation of qualified proprietary nursing homes. (Subsequently this was extended to provide the same kinds of benefits to nonprofit facilities.)

1950s Improvements in Social Security benefits were provided through significant increases and extensions of benefits to the disabled and through improvements in the earned income limitation provisions.

1960 Congress passes the Federal Assistance for the Aged Act to provide a program of federal financial assistance to the states to furnish care for the indigent and the medically indigent for a very wide variety of institutional and noninstitutional programs. Activities for the White House Conference on Aging were initiated and undertaken throughout the United States at local and state levels.

1961 White House Conference on Aging was held.

1965 Title 18 of the Social Security Act (Medicare) was passed, providing for, among other things, payment of posthospital care in extended care facilities.

Title 19, the Medical Assistance title, was passed, requiring states to include in their vendor payment programs inpatient and outpatient hospital services, laboratory and x-ray services, skilled nursing home care, and physician's services. Amendments to the Social Security Act were passed providing for grants to the states to aid in meeting the cost of care for persons 65 and over receiving the equivalent of skilled nursing care and active treatment in state hospitals for the mentally ill.

The Older Americans Act was passed, setting forth congressional policy concerning older Americans, defining the responsibilities of the state and federal governments, and providing for demonstration projects, research, and training programs.

1968 Congress authorized the President to call a White House Conference on Aging.

Intermediate care facilities were recognized as another type of facility that qualifies for federal participation in payments to indigent persons.

The Social Security Act was amended to strengthen the enforcement activities of the individual states in regard to nursing homes. The amendment provided that no federal matching funds be paid to any nursing home not fully meeting state requirements for licensure. In connection with the medical assistance program for skilled nursing home care, the act was amended to provide that states require a medical evaluation of each patient's needs prior to admission, followed by regular and periodic inspection (by an independent review team consisting of physicians and other health and social service personnel) of care being given to medical assistance patients in nursing homes.

1969 President Nixon called the White House Conference on Aging and initiated planning activities.

1971 The White House Conference on Aging was held. The Secretary of Health, Education and Welfare appointed a special assistant on nursing homes to deal with the problem.

1972 Congress passed the Nutrition Bill for the elderly, authorizing an expenditure of $100 million to improve

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the nutrition of elderly Americans during fiscal 1973 and $150 million during fiscal 1974.

1973 Older Americans Act amendments:
- o to provide $543.6 million for fiscal 1973-75
- o to provide "such sums as necessary" for various federal programs
- o shifted the Administration on Aging from HEW's Social and Rehabilitation section to the Office of HEW Secretary
- o established National Clearinghouse for Information on Aging
- o created Federal Council on Aging
- o authorized grants for training and research in the field of aging
- o authorized funds for the establishment of gerontology centers and for special transportation research projects.

Social Security Act amendments:
- o extended Supplementary Security Income (SSI) coverage and increased benefits
- o altered distribution of Social Security payments to increase old age and survivors payments and disability and hospital insurance
- o extended Medicaid coverage to SSI recipients.

1974 Actions by Congress:
- o increased nutrition funding
- o authorized $35 million in grants to states for transportation programs for the elderly
- o expanded the authority of the National Institute of Arthritis, Metabolism, and Digestive Diseases to "advance the attack on arthritis."

1975 Health Services Program begun:
- o required that new and existing mental health centers seeking financial aid provide specialized services to the elderly
- o authorized grants to establish, operate, or expand programs providing health care at home; priority areas were those with large number of elderly
- o established national commissions to study mental health problems of the elderly.

Congress urged states and communities to provide health care services to the elderly at home to prevent undue institutionalization.

1976 Supplementary Security Income [illegible]ibility was broadened.

1977 Food Stamp program changed to allow some recipients to receive stamps without paying for them.

1978 Older Americans Act amendments:
- o authorized funding for home-delivered meals programs
- o expanded purpose of the act to include providing "a continuation of care" for the "vulnerable elderly."

1980 Swing-Bed legislation enacted. Long-Term Care Channeling Demonstration Programs initiated by the Health Care Financing Administration.

1981 The Federal Block Grant System. Enacted Hospice benefits (effective 11/1/83).

1982 The Tax Equity and Fiscal Responsibility Act of 1982
- o flat rate payment per inpatient care
- o limits on payment per case
- o hospital-based physicians
- o outpatient physician services

1983 The Social Security Amendments of 1983
- o Medicare Prospective Payment based on Diagnosis Related Groups (DRGs)

LIFE EXPECTANCY

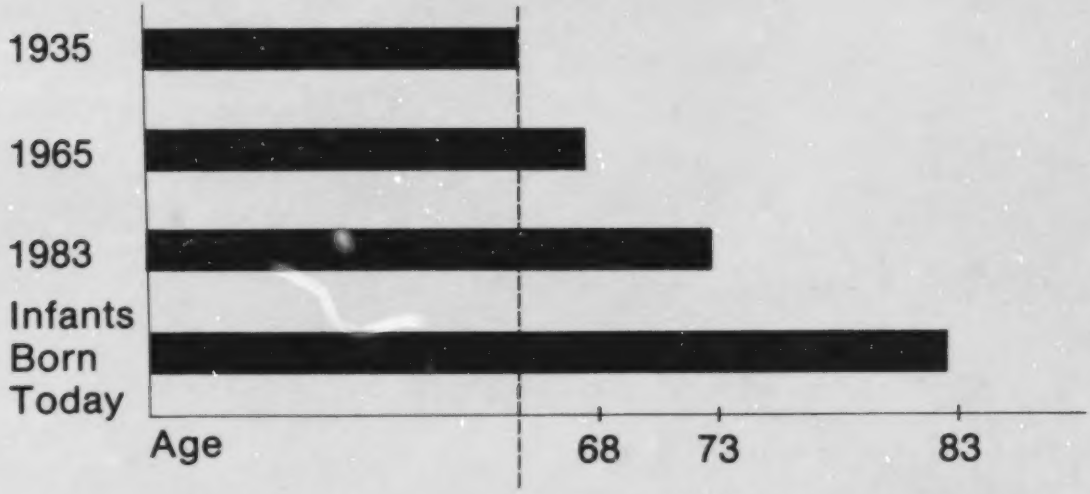


Exhibit 12

MEDICARE EXPENDITURES IN HOSPITALS

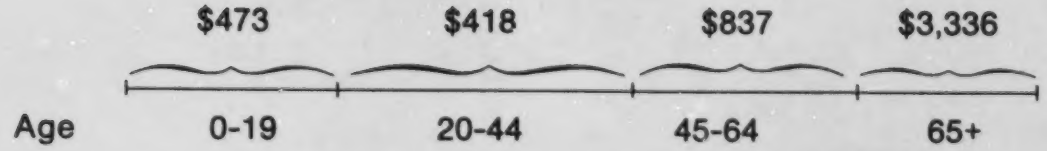
- 70% spent on the last year of life
- 15% spent on the last two weeks of life

Exhibit 13

49

PER-CAPITA COST OF HEALTH CARE

1982



Average annual cost over the lifespan: $1,241

Exhibit 14

TRENDS

- Need for long-term solutions to replace short-sighted, short-term expendiencies
- Greater emphasis on self-reliance and self-treatment by individuals
- Growing importance of multiple options and choices to individuals
- Increasing number of aged Americans

Exhibit 15

TRENDS, continued

- Convenience care and noninstitutional care
- Reduction in institutional capacity
- Retrenchment in payment incentives for horizontal care
- Home care, ambulatory care and outreach services
- Information systems available to individuals

Exhibit 16

TRENDS, continued

- Gatekeeper case management
- Competing financing and delivery systems
- Corporate restructuring of providers, diversification and vertical integration of delivery systems
- Growing numbers of physicians and health personnel
- Jurisdictional disputes among health care providers

Exhibit 17

PRINCIPLES OF CONSUMER CHOICE/COMPETITION

1. Behavior and demand for health care services can be modified if consumers have personal involvement in health care plan selection

Exhibit 18

PRINCIPLES OF CONSUMER CHOICE/COMPETITION

2. Consumer choice demands will create more competition, bringing greater self-imposed discipline among consumers, providers and insurers

Exhibit 19

Mr. SKELTON. Congressman Daub.

Mr. DAUB. Just a brief question. Do you know what the precise figure is on physicians in Missouri who accept assignments?

Mr. DAUNER. I believe it's 58 percent.

Mr. DAUB. Then you're over the national average here in Missouri.

Mr. DAUNER. Yes.

Mr. DAUB. I commend your state for that because the national average, I think, is just reaching 49 or 50 percent. You're doing better here. I'm delighted to know that.

You didn't touch on it, but in your testimony, you do address the new provision of the Social Security Reform Act, which will provide for 467 DRGS, the new alphabet soup that all older Americans are going to have learn about. That "Diagnostic Related Group," which affects the medicare portion of in hospital reimbursement for services or procedures.

Is it going to work?

Mr. DAUNER. It changes the incentives directly for hospitals and I believe that it has some positive aspects and has the potential to be successful.

Mr. DAUB. Is that going to force a cost shift to the younger and working patient?

Mr. DAUNER. Partially for the short term and the reason for that is that during the adjustment, the 3-year transitional phase, as hospitals convert to diagnostic-related payment from medicare, they will be scrambling, changing, and trying to readjust the way they operate and the way they price services. But 50 per-cent of the days in Missouri hospitals are medicare and the hospital will not end up with ultimately two approaches providing services and pricing of services. We are moving from a perday, per-ancillary service system to case-management care. And once that occurs, we will phase out of the so-called short-term price shift.

We see in the private sector in Missouri PPO's, HMO's, IPA's, and a number of other competitive models developing, that will also move toward case-management and we will eventually end up then, toward the end of this decade, with prices for diagnostic-related groups. In other words, for the 467 DRG's, we will have prices for those and they will be inclusive, as opposed to the piecemeal-pricing mechanism that has been promoted, by the way, over the years from medicare, as well as private insurance.

Mr. DAUB. Let me elaborate briefly and quickly for those who are attending the hearing today. The diagnostic-related group was a very responsible action on the part of Congress because we recognized the political problem with curing what will soon be if it is not already, perceived as a crisis in the funding for the medicare program, which is a part of the payroll tax and the social security system. We are commencing to deal with this problem now, rather than when the system gets to the brink of financial difficulties, which is projected to be about 1986. We have established the DRG's to try to get a headstart on the insolvency question and provide proper reimbursement. The responsibility for the success of this idea is going to rest upon the providers and those of you out there on the front line dealing with, for example, a cataract operation. What we want you to know is that it means that if your price—and

this is a price-fixing process, if you will is $1,000 for that procedure and service, which is common for elderly illness, it will be classified in one of these diagnostic-related groups. The price will be set by what that hospital's prevailing rate for that operation has been for a year and it will be tested against the area and regional price for that same procedure and/or service. If the hospital can do it for $900, they get to keep the extra $100 as profit. If their charge is $1,100, they can't bill the patient for that extra $100 and, technically, because of the audit procedures, should not be allowed to cost shift that to someone else. That's going to leave competition in the marketplace, so we continue to get the best quality care we can get. There is no system better but, at the same time, it puts a lot of stress on you, as you just pointed out, in the hospitals to go to this case management procedure rather than looking at cataract operations as something we can just charge $1,000 for and not really justify that cost. So I think it's a start and I'm glad to hear your positive view of that on behalf of the hospitals in Missouri.

Mr. DAUNER. We realize that there will be more changes in hospitals between now and 1990, than have occurred in the past 50 years. We accept that challenge and we are doing our best to try to respond because we realize that we have the problems of health-care costs, accessibility, technology, and we can't do it alone but we're doing everything we can and that's why we said that the marketplace health-care system, we believe, is constructive over the long term and that must involve the other providers.

Mr. DAUB. It's pretty hard, you know, when inflation is 4 or 5 percent to read about medical-care costs going up by 14 or 15 percent. Whether or not that justifies the percentages, somebody in those systems isn't doing enough to level those costs. So the monkey is on your back, to a large extent.

Mr. SKELTON. Mr. Dauner, thank you so much. I really appreciate your being with us. Your oral statement and written statement are outstanding. We appreciate your taking time to prepare it for us.

Mr. DAUNER. Thank you.

Mr. SKELTON. We're running 3 minutes behind schedule but we're doing well.

Charles Braithwait, executive director of the West Central Missouri Rural Development Corp. This gentleman has long been a friend of mine and when I refer to development corporations, as such, in my conversations with people in Missouri and out of Missouri, I always use the West Central, Mr. Braithwait's, as an example. I think he does and has been and is doing an outstanding job. We appreciate your expertise and thanks for joining us.

STATEMENT OF CHARLES BRAITHWAIT, EXECUTIVE DIRECTOR, WEST CENTRAL MISSOURI RURAL DEVELOPMENT CORP.

Mr. BRIATHWAIT. Thank you, Congressman and Congressman from Nebraska.

We very much appreciate you taking the time out of your busy schedule to be here in Missouri, and as you well know, Congressman, Missouri being one of the highest in regard to percentage of elderly and percentage of need of the elderly in regard to consider-

ing the Nation. We also feel that your emphasis and interest in the elderly population speaks well of your tenure in Congress and speaks well of the areas that you represent. So we, your constituents, thank you very much for this concern and for this interest.

Mr. DAUB. Excuse me, but we'll give him some more time.

Mr. BRAITHWAIT. I'm executive director of the West Central Missouri Rural Development Corp., which is a ninecounty rural area in western Missouri, in Congressman Skelton's district. It covers a very, very wide area, some 6,500 square miles with almost 175,000 population.

I would like to make my particular remarks toward the needy in regard to the elderly. I think that we're still at that level. It's interesting that we have heard some four very expert witnesses testify to this point, in regard to the needs of the elderly and I think that that speaks for itself as to this particular testimony today and, of course, the needs that we have more than possibly the services that are available in regard to the need to the elderly. But in saying all of that, not to ever forget that there are those—and many of those—who are capable, at least financially, of taking care of themselves and yet have other needs, also.

But I think this Nation is still to the point to where we are speaking mainly to the needy elderly in regard to legislation, appropriation, et cetera. Medical facilities, for one, in the rural area, is very, very difficult if no other reason, in regard to specialty services and the ability to transport to those specialty services, not only for the individual but for the family and we've talked to the sociological aspects of this and how for the needy and for the family of the needy elderly, this is very difficult to do when they have to go to Columbia, and the city of St. Louis, or even another State. Also, for the elderly, the trauma that we sometimes set aside because we're so interested in those direct needs of the cost of all that the elderly must see and the gentleman previously spoke to this. It is a major concern to the elderly that affects their mental stability at that time. There are very, very few ways in which the elderly have additional incomes, again the needy, and so the trauma of worrying about how they are going to pay for costs directly affects their mental and physical health.

Also an increasing area of concern for the elderly is in regard——

Mr. SKELTON. What you're saying ties in very much with what Mrs. Lubker so adequately explained to us earlier.

Mr. BRAITHWAIT. That's correct and it has a direct bearing in regard to the medical costs in that we're speaking to with the professionals.

Another major that we're seeing that I have not heard a great deal addressed this morning is our energy prices. We are all very conscious of——

Mr. SKELTON. Or try the coming telephone rate increases.

Mr. BRAITHWAIT. I am afraid to try to even project that one because I'm not sure we've got enough information yet, except it's going to be considerably higher.

Mr. SKELTON. Congressman Daub and I have touched on that individually and it's a great deal of concern to us and the record shows and reflect our continuing concern with it.

Mr. BRAITHWAIT. I appreciate that because that's one that we in the field have not even addressed at this point that will be a major concern again for this special group.

I have one brief letter in regard to energy that I would like to quote and I will do it quickly:

> I am 69 years old, paralyzed, have used a wheelchair for 20 years, still can't walk. I would appreciate it if you would help me with some of my fuel bill. I have paid $101.53 for heater oil this winter and owe $214.43. Didn't have the money to pay for the oil when it was delivered. I will still need to buy more before spring. My daughter and family live with me to help me to bed and out of bed. There are five of us that live here. If a representative calls on me, please come to the south door. We don't live in the front room in winter as we don't heat it. Heater fuel is so high, sometimes we don't hear people that come to the front door. I live the first building north of the grocery store that is a black building. I do not draw Social Security. I would, indeed, appreciate some help if you feel that you can give me some.

End of letter.

This is typical. We have many, many even worse than this, if you would, in regard to the plight of the elderly poor, especially in the rural areas and especially minorities.

Needless to say, these letters and others cause our people in our agency and other agencies to strive as hard as they can with the resources available in order to assist these individuals who are desperately in need.

The assistance which you asked me to speak to, Congressman, in regard to what we presently have in the field: West Central provides to all poor persons, regardless of age. The particular Federal and State programs that are involved, such as health, employment, education, food, housing, to as many as we possibly can, and we find ourselves heeding to the elderly because, again, of their special needs. Clinics are provided through many organizations for the basic medical such as blood pressures, the basic things that need to be tested so that they would not have to go into the highpriced professional situation, such as hospitals or doctors offices.

The weatherization program has been well within the help and assistance that is necessary to help elderly citizens conserve the energy costs, conserve fuel, and others, in regard to installing storm windows and doors, minor repairs to foundations, and roofs, and caulking, et cetera.

But—and I would say this at the end, also—this is only for a few. We have not begun to speak to the major percentage of the population, but only to a few and so quite——

Mr. SKELTON. And these are the few that contact you that are some way or another directly or indirectly seeking assistance, is that correct?

Mr. BRAITHWAIT. And we seek out those that are most needy. But it's still numbers. There are still so many dollars and so many numbers that can be involved in a weatherization program or whatever we're speaking to.

Also, we have had opportunity in regard to organization of senior citizens who are beginning to get into the legislative arena. And so, whether we like it or not, whether our elected officials like it, or not, I am glad to say that you do because, Congressman, you've spoken to many of our senior citizens groups such as our Silver-Haired Legislature that we have statewide here in Missouri, such as the Gray Panthers, who are a more active organization, if you

would, in regard to legislation and in regard to priorities. I think we're going to see more and more but, again, this is only for a few, not for the many that are involved. We also have developed craft shops where they might supplement their income with crafts that they have, either in their homes, such as antiques or crafts that they have made themselves. You see this in many of the nutrition sites of the Area Agency on Aging and things like this but only for a few.

We are now developing—and the president from the hospital association previously spoke to this, in regard to home health agency—type organizations, in regard to in—home service programs, the title XX of the Social Security Act now provides financial assistance for. But again, we are just beginning to develop these in our particular area.

Also there are programs for nutrition, there is the retired senior volunteer program, RSVP, the Older Adults Transportation System [OATS]; there is the University of Missouri Extension which provides many of the training and forum—type discussions that senior citizens have. But even with the multitude of services that these and others, State, Federal, private, not-for-profit, public, for profit, whatever the case may be, organizations, when you put them all together, we are still only serving a minimal number of the needs of these senior citizens.

Now, all of us who can hear or read have known for sometime the major deficits that we are now in as far as our Nation is concerned. We know of the priorities that this Nation has in regard to defense, in regard to the national debt, in regard to many other things that we have but I think if these organizations which are in place and which I feel are reasonable delivery systems, both the experts, the professional hospital, the university and the other for-profit or not-for-profit organizations that are involved in the delivery system to senior citizens have some priority, have some appropriation that can assist more of the senior citizens, have some priority, some appropriation that can assist more of the senior citizens, or we are actually going to lose ground.

So briefly summarizing my testimony, I appreciate the opportunity to come and say these things to you today.

Mr. SKELTON. Congressman Daub.

Mr. DAUB. I appreciate your taking the time to focus our attention and submitting to the record the significant contributions the West Central Missouri Development Corp. is making. It is unique in the country, I am advised by Congressman Skelton, and it ought to serve as a model for our other committee members who need to be informed about it.

[The prepared statement of Mr. Braithwait follows:]

PREPARED STATEMENT OF CHARLES BRAITHWAIT, EXECUTIVE DIRECTOR, WEST CENTRAL MISSOURI RURAL DEVELOPMENT CORP.

Thank you for inviting me to testify before you today; I very much appreciate the opportunity. Your willingness to receive testimony from professional service providers in the field of Aging, especially with the demanding and difficult schedules you have, is a high mark of your sincere interest and dedication in regard to the needs of the elderly, especially the elderly poor, throughout the United States.

My name is Charles Braithwait, Executive Director of West Central Missouri Rural Development Corporation, a local Community Action Agency serving resi-

dents of Bates, Benton, Cass, Cedar, Henry, Hickory, Morgan, St. Clair, and Vernon Counties in Missouri.

The area served by this Community Action Agency encompasses 6,110 square miles of west central Missouri. Census information (1980) indicates a population of 159,700. The counties served by this community based organization are rural in nature and are faced with those problems inherent in rural areas: lack of industry, absence of public transportation, high unemployment, and migration of youth into metropolitan areas and away from the rural setting, which results in a population consisting of a large number of senior citizens living on fixed incomes.

Industry is slow to develop in an area lacking utilities, transportation, and skilled labor. What industrialization has taken place has been in a very few population centers and has made an insignificant impact upon the total area labor force.

Faced with these realities, youth abandon the area and leave a population of which approximately 28 percent are elderly (55 years of age and over) and a total of 70 percent of the population earn less than $4,860 per year (pre-1980 Missouri Census Statistics). These figures readily expose a major problem in our area; that of being both a senior citizen and low-income.

Medical facilities are few and far between within the area. Major medical care requires transportation of patients to metropolitan areas (Kansas City, Springfield, or Columbia). For the poor, proper medical care is non-existent. Proper care costs money and for these people, food takes precedence over medical care.

The logic that residing in a rural area is less expensive than an urban setting is a fallacy due to the fact that the amenities of life are more scarce and located geographically further apart in the rural area; thereby often making their cost of acquisition higher. Especially for the elderly, the trauma and cost of obtaining needed goods and services is overwhelming. In reality, fewer businesses and the resulting lack of competition in a rural area often result in highr costs of goods and services under the free enterprise system.

An increasing area of concern for the elderly living on fixed incomes is the many problems arising as a result of the energy crisis. With virtually no public transportation available in the rural area, fuel for automobiles, for those persons who can afford to own them, is becoming a luxury rather than a necessity. Needed trips to purchase such basics as food, clothing, drugs, and to secure medical services must be canceled or postponed beyond the point of actual need. Buying gasoline for recreational activities, for which years of planning and saving have occurred, is becoming practically non-existent due to the exorbitant cost of gasoline.

The cost of heating homes and supplying homes with the other essential utilities has also become an increasingly heavy burden upon the elderly. In many of our communities, the last five years have seen doubling and tripling of utilities costs. To persons living on fixed incomes with no corresponding increases in incomes, the effect has been devasting. The elderly are especially vulnerable to rapidly rising fuel costs as the spiraling rate of inflation has eroded their discretionary income and prevented them from making needed repairs on their homes. This, in turn, has caused these homes to fall into a state of disrepair requiring large amounts of fuel to maintain at least a minimum comfort level.

To demonstrate the frustrations facing older Americans in rural Missouri, let me read you a few excerpts from some of the unsolicited letters received by our agency.

Dear Sir: "I am 69 years old, paralized have used a wheel chair 20 years, still can't walk.

I would appreciate it if you will help me some with my fuel bill. I have paid $101.53 for heater oil this winter and owe $214.43. I didn't have the money to pay for the oil when it was delivered. I will still need to buy more before spring.

My daughter and family live with me to help me to bed and out of bed. There are five of us that live here.

If a representative calls on me please come to the south door. We don't live in the front room in winter as we don't heat it, heater fuel is so high. Sometimes we don't hear people that come to front door. I live the first bldg. north of the grocery store that is a black building. I do not draw Social Security. I would indeed appreciate some help if you feel that you can give me some."

Dear Sirs: "I am 76 years old, live alone, on a little used road. I do not have transportation to come to your office. I do have a phone—but not always dependable in severe windstorms & etc. Your reply appreciated."

Dear Sirs: "Would like very much to know if I am eligible to receive help with my gas heating bill.

My gas bill was over $9.00 higher from Dec. 11 to Jan. 11 and as it has been colder since Jan. 11 till now know my gas bill will be even higher than before.

My Social Security check is $135.70 a month and I get $65.70 SSI. Which helps pay my Dr. and grocery bill.

I'm just not able to do any work if I could get a job." (She is 69 years old.)

"Will you please let me know if you can help me."

Needless to say, reading many letters such as these received by our agency creates a desire within our staff to strive to do more in meeting the needs of low-income elderly persons residing in our area. West Central provides services to all poor persons, regardless of age, in such areas as health, employment, education, and housing, but because such a large portion of our population is elderly, we find ourselves keying our emphasis on the needs of our area's elderly.

Clinics provided by the agency check blood pressure in an effort to promote an awareness that might circumvent major health problems. The weatherization program, as implemented by West Central, provides our area's elderly with the installation of storm windows and doors, minor repair of foundations, windows and roofs, caulking, and insulation so that the area's elderly will have warmer and more secure homes.

A mechanism has been generated to bring the priorities of the elderly into the legislative area. Currently our local area is fortunate to have a Senior Citizens Senate with approximately 4,500 members. This many people in a united effort has had noticeable effect on local policies and priorities at the community, county, and state levels.

West Central has also been instrumental in developing five senior citizens craft shops which provide elderly residents a method of marketing handmade handcraft items which in turn provide a much needed source of supplemental income.

West Central employs 54 half-time home service aides in the In-Home Service Program. This program is designed to allow older persons to remain in their homes and avoid an unwelcome move to a nursing home or rest home. These services would include light housekeeping, cooking, personal care, arranging medical appointments, transportation, and simple home repairs. Many times assistance in just one of these areas could make the difference between being able to continue living at home or being forced into institutionalization. Because most recipients of the In-Home Service Program live in rural isolated areas, transportation to available medical and social services facilities is the single largest expense.

The agency is currently entering into a certification process with the Missouri Division of Health whereby West Central will officially be designated as a Home Health Agency with the capability of providing skilled nursing service, physical therapy, and home health aide services.

Other agencies and/or programs which provide services for the elderly and which compliment the services provided by West Central include the Area Agencies on Aging's Nutrition Programs, Retired Senior Volunteer Programs, Older Adults Transportation System, etc. Even with the multitude of services, man-hours, and dollars spent in trying to meet the area's need, West Central is only now serving a small portion of the area's elderly population. To meet the ever increasing needs of the elderly, more manpower, more dollars, and more or expanded services are required.

Once again, thank you for the opportunity to testify before you today. I appreciate your shared concern of the inequities imposed upon the elderly population today.

Mr. DAUB. Volunteering local government support may tend to be out of the budget constraints that we're going to face. It's not going to be just for the short term. I wish it could go away but it isn't going to, it's going to take a long time and we don't want to throw the baby out with the bath water by overreacting. With respect to those budget deficits, trying to tighten that all at once is impossible because when you do that, you're going to jerk the rest of the system somewhere else.

Try to take a moderate and well reasoned approach to it. What programs, at the Federal level, should we be spending more on? Also if you'd care to risk saying, what programs should we spend less on?

Mr. BRAITHWAIT. Being out of time, as many of you good Congressmen say, due to the fact I have a plane to catch, answering the latter first, there is always some waste. There is waste whether we sit down and eat our food today, or whether they are Govern-

ment, or whether it's a forprofit hospital, or whatever the case may be. But I do not know of any social service program for the elderly of magnitude, of major national size, that we should do away with or decrease.

Then from there, I think we have to carefully look to the basic need the individuals may have which, of course, is the food, shelter, clothing, transportation, medical expense that we have. So I think if we stick to the basics and do away or cut down on the frills, yes, they are nice. Yes, it's fun to go to Disney world or whatever the case may be and people should be allowed to do this if they so desire. As far as Federal subsidized programs are concern, stick as directly to the basics as we possibly can.

Mr. DAUB. So do what your organization does, then. You use the word "needy."

Mr. BRAITHWAIT. Yes, sir.

Mr. DAUB. And it almost seems to me like somehow you deliver services based upon making an assessment of that person's condition. If they are a little bit better off than most, they don't get any help from your group, right?

Mr. BRAITHWAIT. I was interested in the means discussion that you had earlier in regard to social security. That is a bad word but, no, it's not when we are prioritizing dollars and when we have a national debt of $200 billion, it's not then a bad word.

Mr. DAUB. Thank you very much.

Mr. SKELTON. Thank you so much. Actually, you have answered the two questions I would pose to you.

Mr. DAUB. We think alike.

Mr. SKELTON. Thank you so much for being with us. We're going down to your neck of the woods very shortly and look forward to having discussion with you down there.

I would like the record to show without objection the insertion of the testimony of Lorna Wilson, Janice Sondberg, Lauren Harmon, Alice Jones, Sol Moleny, Rev. David Henry, and as you know, we did not have time for all these folks to testify but they have some interesting testimony.

Lorna Wilson is with the Cole County Health Department, Janice Sondberg is with the Heisinger Lutheran Retirement Home, Alice Jones is with the Foster Grandparents program and we appreciate their testimony.

[The statements submitted by Representative Skelton follow:]

COLE COUNTY HEALTH DEPARTMENT,
Jefferson City, Mo., September 6, 1983.

Hon. IKE SKELTON,
Member of Congress,
Washington, D.C.

DEAR CONGRESSMAN SKELTON: I am pleased to be asked to submit testimony to the Select Committee on Aging. I am Director of a county health department which serves a population of 55,000 people. We are very much involved in services to the aging, specifically in health counseling of families regarding health care for their elderly members, home health services, hospice care and hypertension monitoring services.

Because my experience is in community health services, I will address those issues of aging that have to do with the economics of health care and the availability of health care to the aging.

Physician care for in and out-patient services is readily available to medicare eligible patients in our area. Costs to the patient for physicians' services do not appear to be an inhibiting factor to obtaining such care.

The cost of medicines to out-patients and to nursing home patients is however a serious problem. Many patients have monthly drug bills in excess of $100.00 per month. If these patients are living on social security benefits alone, as many are, they cannot afford to purchase their medicines in addition to paying for food, utilities and housing.

I believe that the cost of medicines needs to be studied at the manufacturing and retail level as well as the prescribing situation. The elderly patient is subject to chronic conditions requiring long term medications such as diabetes, arthritis, hypertension, cardiac arrythmias, and other vascular disorders. It may well be that medicines for these conditions are the ones with which the elderly need assistance, rather than over-the-counter medications or short term prescriptions. Whatever benefits are considered in the area of medication they should be done so with the philosophy that "fewer is better" rather than promoting more and more medication usage—a problem which now exists and a problem which causes more difficulty than it alleviates.

The enigma of safety of medication distribution in nursing/boarding homes versus cost of unit dose packaging could also stand scrutiny. I can argue both sides of this question but I feel there could be some middle ground which would permit the lower cost use of stock medicines for patients who are on the same medications. The increased cost of skilled medication distribution versus the decreased cost of medication will have to be considered.

The second problem of health service availability related to cost is the hearing aid. Hearing aids, in this age of the $9.99 transistor, are remarkably high priced. I believe this market also needs to be studied at the manufacturing and retail level. There is no reimbursement for this expense to my knowledge but the level of expense is far beyond many elderly persons' needs, exaggerating their isolation and subsequently, their ability to cope with their environment.

Third, and similar in cost and lack of reimbursement, is dental care. The cost of dentures to elderly patients is often prohibitive, compromising their nutrition status, not to mention the losses in appearance and communication.

Transportation to medical care continues to be a problem, for the rural elderly particularly. Our county has several small villages and cities which have no public transportation. Although the OATS service has been a great help, it has not solved all the needs, particularly for the handicapped patient.

High utility costs are creating and exacerbating existing health problems for elderly people. As community health nurses, we frequently see patients who do not use their air conditioners in summer or keep their thermostat turned down in winter because of their fear of high utility bills. These very low or very high temperatures add to the seriousness of chronic cardio-vascular or pulmonary problems.

Finally, I would add a comment about the recent medicare Hospice regulations. Although I have studied only a summary of these regulations, two things cause immediate concern. First, I find it restrictive that medicare Hospice services will be available only to patients who are physically competent and able to sign an election form. This prevents needed hospice services to many elderly whose families have elected to care for them at home. Social and psychological support services are important to the family care givers of dying patients. Secondly, financial responsibility of in-hospital services has been given to the Hospice agency which may work very well for large agencies, but will prevent the small community Hospice from participating. The Hospice in our community connects with three hospitals and several home health agencies to provide their volunteer and social services to dying patients whether in or out-patients. As the regulations are now proposed, an agency such as ours could not participate and the regulations appear to be encouraging further duplication of services by requiring Hospice to supply all care services, rather than to contrast for services they do not have.

Any federal medicare regulation which encourages further multiplication of service agencies is not desirable in my view.

Again, I thank you for the opportunity to express my views on elderly health problems. I have a real concern for these problems, as a public health professional, as a tax payer and as a future consumer.

Yours very truly,

LORNA WILSON, RN,C,MSPH,
Director of Health Services.

PREPARED STATEMENT OF JANICE SONNENBERG, ADMINISTRATOR, HEISINGER LUTHERAN RETIREMENT HOME

THE ECONOMICS OF AGING: A NEED FOR PRE-RETIREMENT PLANNING—SPECIAL CONCERN: LONG-TERM HEALTH CARE

It is impossible for individuals to make specific long-range plans for health care during retirement because no individual knows when or if he will need expensive long-term health care. The Federal Government's roll should be to encourage private enterprise to offer a full continuum of service at a reasonable price so that individuals will be able to find the services they need when they need them. The Federal Government should not be in the business of assisting individual citizens to make choices about how they will spend their retirement years or even prepare for their retirement years.

At the present time the Federal Government is heavily subsidizing nursing homes and is beginning to subsidize home health care. The result is that these parts of the continuum of long-term health care (such as nuring home care) more and more people are drawn to that particular part of continuum are expensive and readily available. Other parts of the continuum such as care by relatives and adult boarding facilities or residential care are still relatively inexpensive but frequently not used or not available. When the Federal Government subsidizes one part of the continuum. There must be a more balanced approach to the entire continuum of long-term health care to discourage the overly heavy usage of the most expensive types of long-term health care.

Because people are living longer and the birth rate has gone down, it is becoming even more important to lower the costs of long-term health care. Future generations will not be able to continue the expensive types of health care which we are financing at this time. The ratio between taxpayers and retired people will become less and less. Those taxpayers will also have to pay the interest on the huge deficits we are now acquiring. If we cannot pay for the care of the elderly now, how can we expect them to pay for it then?

When both the state and Federal Governments are governing the long-term health care industry it is very difficult to make changes. I believe the only way to find more innovative ways to deal with rising costs is to give a number of states block grants to cover Medicaid for long-term health care. I think it would be really exciting to allow Missouri and several other states to try it first and then analyze how much money was saved and how people were cared for. Certainly state governments can make mistakes, but the Federal Government can also make mistakes. And the Federal Government has the disadvantage of being far removed from the problem.

Here are some ideas for providing a more balanced and less expensive program to care for the frail elderly:

Nursing home care: Change the complicated Medicaid payment to nursing homes to one flat rate. The present system encourages newer, fancier buildings and frequent changes of ownership and management. People do not necessarily get better care in newer facilities, but they always get more expensive care. It is the only industry I know where new facilities are built so that the product can be produced in a more expensive way rather than a less expensive, more efficient manner.

We should also require children to help support their parents who receive Medicaid for long-term health care. Certainly this would not be easy to enforce in our mobile society, but it would have some beneficial results. It could help to strengthen the family by recognizing the permanence of family ties. Families that are able might decide to care for their loved one at home.

Home health care: Medicaid has only recently begun to pay for home health care, but the costs have already begun to go up dramatically. A visiting nurse costs around $30 and hour in our area, and much more in some other areas. The price doesn't bother anyone as long as someone else is paying for it.

Home health is very beneficial for some people, but tight caps must be put on its cost and usage. One fairly low flat rate for each kind of home health service would do a lot to keep the program under control. It would also help to require the family to help with the cost of this program also.

Boarding home or residential care: This is one part of the continuum that is being most neglected in most states. Missouri has encouraged the development of residential care facilities and adult boarding facilities with very good results.

Adult boarding facilities or residential care facilities are homes where elderly and handicapped residents receive personal care such as medicines given, meals prepared, help with baths and other personal care, and housekeeping services. There is

a minimum of nursing care. Of course, these homes are only able to care for ambulatory, mentally-competant individuals. People who can't live alone can come into a residential care or adult boarding facility and maintain a higher level of functioning for quite some time so that they don't need to enter a nursing home.

In a needs assessment of Missouri's nursing home residents, 12 percent of all Medicaid-subsidized nursing home residents did not require a nursing home level of care. Missouri has developed a point system which will determine what level of care a resident really needs. It is hoped that this percentage will gradually go down, as residents are moved to appropriate levels of care.

Most of the people included in this 12 percent would find it difficult to live alone. They would, however, be able to live with someone else or in a residential care facility or adult boarding facility.

The biggest bonus of all is that these lower levels of care are much more socially desirable. Residents are able to continue to function in a much more normal way, rather than becoming dependent on nursing care which they really don't need.

It has been a long slow process to get this program in place because the Federal Government does not participate in payments for lower levels of care. (Our legislators like to bring as much Federal money to Missouri as possible.) But it has been found that even though the states bears the full cost of this program, it still costs the state substantially less to care for the people in adult boarding facilities and residential care than in nursing homes. The state gives monthly grants to low-income people in Adult Boarding Facilities of up to $126 and monthly grants to low-income people in Residential Care Facilities of up of $236. The average monthly public expenditure for nursing home care in Missouri during 1982 was $805.

To encourage use of this less expensive level of care it would help to allow the residents a monthly amount for spending money. At the present time people on Medicaid in nursing homes are allowed to keep $25 of their Social Security for spending money each month. Residents receiving the state grant in Residential Care or Adult Boarding Facilities do not get any spending money. This is especially difficult, because these people are ambulatory and mentally competant.

Residents who are fortunate enough to have caring families have usually received clothing, occasional spending money, laundry, etc, from their families. But not all residents are so fortunate to have caring families. It would be helpful to require families who are able to deposit a certain amount for spending money and the government could deposit a certain amount for residents with no family.

Care by relatives and friends: At one time this was about the only type of care available, but it is becoming less frequent. This is partly because our society is very mobil and many womem have found employment outside the home. It is probably also caused partly by the fact that Medicaid will pay the full cost of nursing home care, but pays families nothing for caring for an aged parent.

One way to encourage care by the family would be to give a tax credit to those people who care for a relative for the major part of a year who would have been eligible for Medicaid in a nursing home.

In conclusion I have several general comments about the importance of cost containment and reduction in programs for the elderly.

If any relatively young person were to ask me what they should do to plan for retirement, I would tell them *"Save your money."* Because of the demograpahic configurations of our country, when our children and grandchildren reach retirement age, there will be no chance that they will be taken care of the way we are taking care of the elderly now. I am not a demographer, but I am sure that the House Select Committee has studies available which show how the ratio of taxpayers and retired people will be becoming less. If such figures are not available to you, please commission such a study. It doesn't do any good to hide from these facts.

Certainly we need to be helping the elderly, but the Federal Government should not be expected to do the entire job. In my opinion, the Federal Government should be concerned only with income maintenance. Social programs should be funded and carried out by local and state groups. We simply cannot afford the mammoth beauracracy of the Federal Government. Our legislators should remember that the poverty level for elderly people in 1982 was actually less than for the rest of the population.

Unfortunately, this testimony probably gives the idea that I don't like elderly people, but that is certainly not true. I care very deeply about the elderly and I love working with them; but I also care about the future of my children and grandchildren, and about the future of our country as a whole. Therefore I am willing to sound like a "Scrooge" until we can find acceptable ways to reduce costs to a level which we can expect to maintain.

If our legislators care about the future of our country as much as they care about their own future, they will take the necessary steps to reduce cost to a level which can be maintained for generations.

PREPARED STATEMENT OF ALICE J. JONES, FOSTER GRANDPARENT PROGRAM DIRECTOR, MISSOURI VALLEY HUMAN RESOURCE DEVELOPMENT CORP.

I. PRERETIREMENT PLANNING FOR AGING

A. Should have begun in Junior and Senior High School through required studies in courses such as "Personal Finance."

1. Too late for those already considered to be elderly.

2. Usually only offered to college students.

a. Many do not take advantage of this course.

b. A large number of people do not go to college.

B. Could possibly be done in the form of "Retirement Counseling" now for the aging.

1. By means of sessions arranged by Social Security Administration employees at the time seniors sign up for Social Security benefits.

2. As a requirement for participation in all Welfare Benefit Programs.

II. ATTITUDES TOWARD AGING

A. I agree with Dr. Robert Butler, Chairman, Geriatrics and Adult Development Department, Mt. Sinai School of Medicine, when he says the most damaging myths of old age are that:

1. It is sexless.

2. It is mindless.

3. It is useless.

4. It is powerless.

5. It is a disease, not a natural continuing process.

6. All old people are alike.*

B. Some of my thoughts on Attitudes Toward Aging.

1. Many people think the elderly become forgetful because they are elderly.

a. The truth is, there just isn't room in the conscious mind for all the things they have learned in their lifetime.

2. It is often not realized that older people are as in need of demonstrations of affection through hugging, touching, etc., as people of any other age.

3. Many people are unaware that most elderly folks are as young emotionally as anyone of any age; that only their outward body ages.

a. The more we see a person as being elderly, the more "elderly" that person becomes.

4. Many do not give elderly people credit for having any intelligence.

a. They tend to ignore, or condescend, to them.

b. Often at meetings where the needs of the elderly are being discussed, and solutions, sought, the elderly are the last to be consulted.

5. People tend not to realize that the needs, fears, and desires of the elderly are mostly no different than those of people of any age.

6. A great number of people do not realize that an older person's existence is affected by every aspect to social structure; which is created by our attitudes.

C. Some specific problems faced by the elderly as a direct result of the attitude of many are listed below.

1. Health needs.

a. Frequently over-medicated causing mistaken diagnosis of illnesses.

1. A review of all medication being taken—presecription and non-prescription—should be made during every visit to the doctor.

b. Doctors do not realize the importance of doing a health-check for more than just symptoms prompting the elderly to make appointments for medical treatment.

1. The aged should receive complete physical examinations regularly.

c. Training in Gerontology is not considererd to be important.

1. According to course requirements of most medical schools.

d. Inadequate (or NO) information is provided far too often as to;

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*"*Ladies Home Journal*; August, 1983; 02098 Volume C, No. 8; "Old Before Her Time," by Katherine Barrett, (pp. 46, 48, 51, 130, 131.)

1. Possible side effects of many medications.
2. The fact that some medicines are incompatible with certain other medications and some foods.
3. That some health conditions preclude the taking of certain medicines.

e. Many doctors (and other people) overlook the fact that a seemingly minor injury or illness can be so traumatic to the elderly as to send them into a state of shock which should be treated medically.

2. Loss of physical strength;

a. Causes the elderly t isolate themselves in their homes due to a fear of becoming victims of crime (even in rural areas).
1. Seldom are they financially able to move to a safer area.
b. Makes many areas inaccessible to the elderly due to;
1. Heavy or fast revolving doors.
2. Curbs.
3. Steps (on busses and to/in buildings).
4. Lack of transportation.
c. Makes it difficult for the elderly to go shopping because of;
1. Purchases too heavy or bulky for transporting.
2. Jostling by impatient younger shoppers.

III. ECONOMIC ISSUES OF THE AGING

A. Heavily inter-twined with Numbers I and II for meeting the needs of the aging in many areas.
1. Health-Physical, Mental, Emotional, and Nutritional.
a. Sky-rocketing costs keep the aged from seeking proper medical care.
1. Through visits to the doctor as needed.
2. Due to the inability to afford some necessary medications.
2. Housing.
a. The elderly cannot afford home repairs.
b. Affordable alternate housing is frequently unavailable.
3. Transportation.
a. Older persons unable to afford purchase/upkeep on an automobile if they can drive.
1. They can not afford alternate transportation whether they drive or not.
a. Often no alternate transportation available; especially in rural areas.
4. Insurance.
a. Cost for Medical, Homeowners, Property, Automobile is beyond the means of far too many seniors.
1. Policy language generally too technical to be understood by most.
2. Too many unscrupulous individuals taking advantage of the elderly through the sale on insurance.
5. Legal Services.
a. Seldom are they within the price range of the elderly.
6. Utility Costs.
a. Usually are not in the budget range of most elderly.
1. For energy needs winter and summer.
2. For telephone service; especially with the new system that is going in soon.
7. Respect of others.
a. Most people tend to have and demonstrate a low regard for the elderly who are unable to afford;
1. To dress well.
2. To afford adequate housing in a good location.
8. Unavailability of income increasing opportunities.
a. Forced retirement due to age.
b. No one will hire the elderly because of their age.
1. Many do not believe they have potential as employees.

I am sure the many things stated herein only begin to touch on the many problems faced by the aging. It would be impossible for one person to be able to address their every need.

Perhaps one of the greatest obstacles to hurdle in overcoming the myths of aging, is that the elderly themselves have been brought up to believe them, thus they perpetuate the problem.

Extensive education is needed for everyone, in all areas, to bring about an understanding of the position of the elderly, regardless of their financial situation, if there is to be any meaningful change in their circumstances.

I appreciate the invitation to air my viewpoint.

Thank you.

PREPARED STATEMENT OF REV. DAVID A. HENRY, VERSAILLES, MO.

I want to express my appreciation to you for this opportunity to express my view on the economics of aging and the need for pre-retirement planning.

What I am testifying to today is the fact that there are people that even though they have planned and secured their own future with a savings program they can find themselves in a nursing home whose costs are far beyond what they ever anticipated and that their life-savings is quickly gone. It is eaten by the cost of the high level of care that they need that requires them to be in a nursing home. The result is that after their life-savings has been depleted they then have to turn to other sources to pay for their care. Their family might bear the cost, but more often than not it is the government who bears the cost, especially through the Missouri Division of Family Services and through the Supplemental Security Income program (SSI). Their basic needs such as food and shelter are met, and so are a part of their personal needs. But there is an area of injustice in this program that I personally feel needs to be rectified and this is what I want to focus on today.

Beyond the needs of shelter and food, provided by the state, the SSI program gives each individual $25 each month for personal items that are not provided at the nursing home. This includes personal gifts, cards, stationary, permanent waves for women, cigarettes, beverages, etc. Though I do not know the total history of this program I do know that the $25 was the amount that people were getting in the mid-1970's. Inflation these past seven to eight years has reduced the purchasing power of this amount to about 60 percent of what it was in 1977. Almost every person employed in this country has experienced some increase in their wages or salary during these years to offset inflation. Yet this small, powerless segment of the population may well be the only group who has experienced no increase in their income.

Let me point out that it is true that there are those in nursing homes who do not use this full amount. They perhaps do not need to buy clothes because they are in hospital gowns, they may not need new shoes because they do not walk. I heard the story of one man who actually made money on the $25 per month. But those that do get out and are participating more fully in the life of the community need these items. I am here today to say that there are people who because of unfortunate and unforseen circumstances are living in nursing homes dependent upon the government and this $25 is an inadequate amount. They have active minds that need items such as stationary and stamps to keep in contact with loved ones. They have families that want normal rememberances such as gifts and cards and visits on occasion. And where possible, they have need to be away from the nursing home from time to time.

For clarity and because it is the motivating factor for my testimony today I want to share with you an example of such a situation that I am personally acquainted with.

A woman crippled with arthritis was taken to the nursing home by her husband and then later divorced by him. She has no resources to pay for her care nor does her family. She was placed on welfare and given $25 per month from the SSI program. She needs the care and therapy provided in the nursing home and yet this woman has an active mind, participates in her church and tries to be involved in other activities as her physical limitations allow. She has a daughter and three grandchildren. Her father is almost 90 years old. Both parts of her family live in different cities over 100 miles away. When she goes to visit them for a few days she must pay over $25 each night over her two allowed days each quarter to the nursing home to keep her bed. When her grandchildren have birthdays she likes to send them small gifts and cards. She has need for clothes, shoes and personal items such as make-up, devotional material, stamps and so on. Her personal needs are moderate and yet you can see that the $25 amount has to be stretched over a great number of items and is not adequate.

No matter how much planning a person may have done, they could not have forseen these circumstances. I appeal to you on behalf of these individuals who are caught in such cirumstances and where the need is very real, to consider an increase in the SSI program from the $25 per month figure to at least one that would have kept up with inflation over these past years.

Thank you for your time, attention, and consideration of this important issue.

Mr. SKELTON. For our final comments before we adjourn to Clinton at 2 o'clock, I call upon our friend from Nebraska to tell of his interesting conversation and correspondence with the lady that has innocently created a problem for us.

Mr. DAUB. First, I want to say to those who have submitted written testimony, this is not at all unusual. We do appreciate it. I will read your written testimony with interest. The record will reflect it and it's appreciated that you took the time and made the effort to bring this information to further amplify the record.

You can't explain this notch problem in 25 words are less, so I'm not going to try. I will try in about 250 words.

How many of you are aware of the so-called notch baby problem that was raised by Ann Landers in "Dear Abby's" column a week or two ago?

[No response.]

Mr. DAUB. See, that's the problem. Whenever you tell people about a problem they didn't know existed, you create more problems. But if you haven't heard about it, you will, in 1972, Congress adopted an automatic indexation formula called the cost of living adjustment which has, up until this year, been paid every July 1 and will now be paid every January 1. The COLA takes into account inflation based upon the consumer price index and automatically adjusts the fixed benefits or the defined benefit of the social security check upward monthly by whatever inflation was. A new formula is used based on the decrease or increase in January to March of the previous year. That change essentially got Congress out of the political problem of having to deal with whether or not they were going to vote on raising social security every year. Congress, instead, went to the formula which automatically adjust benefits preventing them from having to vote on it.

When Congress did that, they failed to look carefully at the fact that social security benefits are calculated based upon three things—and they still are today—how much you paid in, the increasing wage levels, and the cost of living. That's why we go to the high 5 years or 60 months, and the cost of living indexes. Those three things are still the way in which everyone's social security benefit is calculated.

When they went to the CPI and at the same time used the wage level, wages out in the economy were also affected by inflation. So in 1978, when the social security program was again perceived to be on the brink of financial insolvency, you will remember there was a large tax increase. The contribution of worker and employer was raised not only in amount but against the base. Another part of that reform bill was to take away the double inflation benefit, the payment for inflation twice, first in the wage level formula; second, in the clause.

In 1978, a transition period of 5 years was allowed, called the notch, for those who retired at age 62 or at age 65. Beginning in the year 1979 the phase in extended to the year 1984. This involved people who would have been born in the years 1917 through 1921 or the notch years, to receive benefits adjusted downward. These benefits were phased in on either the old formula or the new formula, whichever would give them the higher benefit during that phase-in period. Therefore, all who retire after 1984, will receive an

inflation factor based on the COLA clause but won't get a windfall, or a double benefit, in the calculation of inflation.

People who did retire in those 5 years, 1972 through 1977, have received that second or dual inflation benefit adjustment. Bills have been introduced in Congress to give back the decrease to all who have retired from this point forward. There is a lot of controversy about it because people think it's unfair. The fact of the matter is, "Dear Abby's" letter said that all those who were going to retire from now on were going to get cut $100 a month. That's not true at all.

As a matter of fact, what might be the case is you won't get as much of an increase as you might have expected and/or there may be a reduction in the increase. However, there is not going to be a cut of $100 in anybody's social security check. Congress, therefore, applied that adjustment to everybody fairly. They didn't single out people just born in those 5 years but found out that a mistake had been made. There were a lot of people who were going to get a double benefit from inflation and that's not fair to others, so they corrected that error in the 1977 act. In addition, ladies and gentlemen, if you went back and tried to give back everything that someone might argue they didn't miss but they didn't get, it would cost us about $8 billion for the first 3 years and who knows how much it would cost in the future. Of course, that money isn't there and was one of the reasons Congress courageously had to bite the bullet and take a look at that double benefit that no one ever expected or counted on. Yet, these benefits ended up generously treating them and taking benefits from others or causing taxes to be raised on the working person. "Dear Abby" called me personally because I said to her, "I got 300 phone calls in my office. I am sure you're pleased to know how widely read your column is but the letter you printed is sadly in error and you need to correct it."

I got involved with "Dear Abby" last week, and helped her write her correction column, which I have yet to see but pray we will be able to handle this very technical, and complicated but very fair decision that was made in Congress in 1977.

Mr. SKELTON. Hopefully, there will be a corrective article that we can understand.

The chairman of the Social Security Subcommittee took the floor in an explanatory minute yesterday and discussed and explained it in much more—much more technically than our friend from Nebraska did. I do not see any change in the offing as a result of his comments and also in light of the fact of the tremendous potential cost. But an explanation is due the American public and as a result of the "Dear Abby" article, I hope that people will receive explanatory answers from that congressman, Congressman Daub and myself.

Mr. DAUB. The point is, no one is being cut and that's where that article was very misleading.

Mr. SKELTON. She did point out, as I recall, $100 cut.

Mr. DAUB. Sure. If $1,200 of somebody's money was cut a year, I'd be upset, too.

Mr. SKELTON. Ladies and gentlemen, we're only 8 minutes behind schedule. We will be able to get the airplane and fly to Clinton.

We will adjourn this hearing until 2 p.m., when we will again take up in Clinton, Mo. It's great of you all to be here, I appreciate the interest and the witnesses have done a tremendous job, you've helped us a great deal and I would hope that those of you who have comments or thoughts that come to mind would feel free to write me in my Washington office, so we can further address the problems that have been raised here.

[Whereupon, at 11:04 a.m., the hearing was adjourned, subject to the call of the Chair.]

THE ECONOMICS OF AGING: A NEED FOR PRE-RETIREMENT PLANNING

FRIDAY, SEPTEMBER 16, 1983

U.S. HOUSE OF REPRESENTATIVES,
SELECT COMMITTEE ON AGING,
Clinton, Mo.

The committee met, pursuant to notice, at 2:00 p.m., at the Clinton Civic Center, Third and Green Streets, Clinton, Mo., Hon. Ike Skelton (acting chairman of the committee) presiding.

Members present: Representatives Skelton of Missouri and Daub of Nebraska.

OPENING STATEMENT OF REPRESENTATIVE IKE SKELTON

Mr. SKELTON. We will convene the second part of our committee hearing today. This is the Select Committee on Aging. My name is Ike Skelton. I am the Congressman from this district. With me today is the Congressman from the State of Nebraska, Congressman Hal Daub.

I want to thank you all for attending this hearing. We have two panels of witnesses who will testify and we, of course, hope to keep an eye on the clock because Congressman Daub has to catch an airplane to Omaha, his hometown, and a bit later, I go to Blue Springs.

Before we go any further with my opening remarks and Congressman Daub's opening remarks, I would like to mention people in our audience that I would like to introduce to you, a young lady that I've known all my life, and another young lady from Marshall, Mo., both made the Foster Grandparent national poster. Hazel Thomas from Marshall, Eva Saunders from Lexington, would you stand up, please.

The topic this afternoon is a continuation of what we were doing this morning, the "Economics of Aging: a Need for Preretirement Planning." It may well be the most central issue to be faced in our Nation's efforts to come to grips with an increasingly elderly population. Now, aging, as you know, is a daily process. We tend to always think of ourselves as being young. And while a youthful attitude is something we always hope to maintain, it mustn't blind us to the realities of the changes in our personal finances, the changes in our physical capabilities, the changes in our medical needs and, of course, the attitude of ourselves and our family and our friends. It is said that knowledge is power. This, in a way, is the purpose of our hearing today. If we can familiarize ourselves with the predictable changes associated with the aging process and learn to pre-

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pare for that, we can give our society the power to overcome the fear and concern of growing older and give our senior citizens the opportunity to enjoy their retirement years.

A special word of thanks to my friend from the State of Nebraska, Congressman Hal Daub. Congressman Daub and I serve on two committees together, the Select Committee on Aging, as well as the Committee on Small Business. He is one of the experts, in my opinion, on problems dealing with aging and with senior citizens, as will become apparent to everyone here, as a result of the very excellent questions he will ask our witnesses.

I might also say that a number of you probably have seen the Ann Landers, "Dear Abby" article, dealing with the notch problem in social security. He will undoubtedly mention to you his personal phone call and letter to "Dear Abby" to correct a mistake that she has made causing many people to think that they are going to get less social security, than they will, so he will a bit later touch on that.

Let me tell you that we have two panels of witnesses today. I wish it would be possible to have many, many more people to testify but because of our time constraints, we must limit ourselves to two panels of four witnesses each.

The first panel is Mrs. Mary Fran Cleary, who is the Director of the Retired Senior Volunteer Program in Clinton; Mrs. Grace McFarland, Marshall, Mo.; Mr. Harold Bradshaw of Clinton; and Mrs. Elberta Kuper. I will ask that this panel prepare itself to come to the table in a few moments.

The second panel is Mr. and Mrs. Leo Porter of Warsaw, Mo.; Mrs. Ethel Mikels of Marshall; Mrs. Julia Taylor of Marshall. So in that order, we will proceed in just a few moments.

Now, it is a real pleasure to introduce for his opening comments Congressman Daub.

STATEMENT OF REPRESENTATIVE HAL DAUB

Mr. DAUB. I don't often get applause at a field hearing. It makes me even more appreciative of the very warm hospitality that has been shown to me. I have thoroughly enjoyed myself this morning at our first set of hearings. It is not only a pleasure to be with you this afternoon, but I want to personally take a moment to thank your congressman, Ike Skelton. He's a good friend of mine.

I first got acquainted with Ike—as a matter of fact, after having watched him when he gave a talk to our Thursday morning prayer breakfast. He gave us some insights at that time into his background and some of the things that challenged and motivated him. I was fascinated by that story, and since that time I have become better acquainted with him. As he said to you, we serve together on the Aging Committee and your Member of Congress, Ike Skelton, is one of the senior and more respected members of that Older Americans Committee. He is so very much involved with the funding, for example, of senior citizens nutrition sites, other programs that are important to you like Foster Grandparents, ACTION and Green Thumb. I know him well and you should be proud of him. He is a great Member of Congress. I would also like to extend my appreciation to him, because he attended a hearing that I held in

Omaha and I am happy to have this opportunity to reciprocate. It is something that I've been looking forward to.

As a member of the House Select Committee on Aging, Congressman Ike Skelton and I both view the Aging Committee as an essential forum for examining the concerns of our country's senior citizens. These field hearings offer a very important source of grass roots views on the issues facing our older population. This kind of a get-together is not just for show. I value the contributions I get a chance to hear here today. Actually, in most cases, I value regional hearings more than the information I pick up in a formal hearing in Washington, D.C. The reason is, a lot of the hearings in Washington are for show. When the hearing witnesses come from all over the country—and I am not saying that those hearings aren't valuable—but I get about 2 or 3 minutes with them because there are 40 witnesses and everything has to go so fast.

So this is a chance for your Congressman and for me to listen carefully to very important views of the people on the front line. They are either consumers of aging programs and/or have concerns about things we're doing right or wrong or are directors of a very important program. So this is key, as far as I'm concerned. Congressman Skelton and I will share the printed testimony in the record with all of the other members of our committee who can't be here today. This testimony is going to make a meaningful impact on how we view the issues that we will have to face.

These are many issues that our country's older population has faced, a population that is growing faster than any other age group. Older adults today total nearly 12 percent of our country's population. By 1990, it will constitute 15 percent of that population.

As our Nation's population continues to age, it becomes necessary to closely examine the factors that will help us deal with retirement and the effect that it's going to have on our lives. Many of us look to retirement as a time to spend with our grandchildren or to work on a special project that we've been meaning to do but just could never quite accomplish or find the time while we were working.

However, for some, retirement can be a very difficult adjustment. All of a sudden, we have too much time on our hands. Yet, one's happiness and health depends on keeping active, whether through individual projects or community service. Senior citizens can contribute helping hands and experience in any community project, volunteer programs consistently need help and senior citizens often supply the nurturing and caring attitude needed to make that special community project a success.

Volunteering helps not only the community but also gives senior citizens a feeling of self-worth and accomplishment. Many senior citizens develop their talents into part-time work, which will help to supplement their incomes. While it is difficult while we are young to concentrate on retirement, we cannot undermine the importance of keeping an eye on the future. Retirement age is here before most of us realize it. We must understand the impact that retirement will have on our lives and the lives of people around us and we've got to plan accordingly.

That's the purpose of this hearing, to help us focus on what government should or shouldn't do to help develop that focus on the economics of aging: A need for preretirement planning.

The Government, indeed, has a role to play in the aging of our country's citizens. Government has intervened to help meet the growing needs of the elderly by providing income maintenance, medical care, housing, transportation, and social services. In the past few decades, people have been assured that they will be taken care of in retirement through social security, which has served as a cornerstone of income security. Through the social security changes that were passed in March of this year, Congress reaffirmed the commitment on the part of the Federal Government to assure older Americans that they will be compensated fairly for their work in their retirement years.

In preparing for retirement, it is also essential to think of how one will supplement social security benefits to achieve an adequate retirement income, whether it is through private pension or retirement savings. One avenue is an individual retirement account, which allows for tax-free savings in retirement years. I use this as an example because I introduced a bill in Congress as a result of a field hearing just like this one, held in Omaha, Nebr., a year ago. At this hearing we focused on the problems of older women and many witnesses told me that they found it very difficult to live on social security and they wished there had been something more that, as a housewife, they would have been able to do to plan for retirement. The joint income of the family was attributed to the husband who worked outside the home. He had a pension but for their contribution to the real growth of the economy in that household through the cooking, cleaning, washing, sewing, shopping, and frugally managing the household accounts, they were not treated in the customary and conventional way. As a housewife that nurtured the family relationship, they didn't get a W-2 form and didn't earn a quarter of credit for social security. And, thus, my spoused IRA bill is gaining great support in Congress. This legislation will, perhaps prevent us from having to rely upon food stamps and other forms of assistance as much in older years.

Finally, a very important factor in preparing for old age was most aporopriately expressed by a very distinguished Missourian. In fact, I think his family has roots in your congressional district, a constituent of yours—someone we all know as Marlin Perkins, the St. Louis Zoo director. Marlin Perkins is famous for his "Wild Kingdom", program which is sponsored by Mutual of Omaha—a company headquartered in my hometown. He appeared at the hearing that Ike Skelton and I held in Omaha several weeks ago and at that hearing, stressed that one's lifestyle and health practices will have the greatest impact on his or her preparation for older age.

As I welcomed that good advice from a very well-known Missourian, I look forward this afternoon to the testimony and advice from residents of Congressman Ike Skelton's district. It's good to be in the "Show-Me State." Now, I might talk about "Dear Abby" later if I'm asked, and I certainly wouldn't mention Nebraska football.

Mr. SKELTON. I think we can rule that out of order.

I would be remiss if I didn't introduce the coordinator who has been very helpful in putting this together, on my staff in Washington, Mrs. Toni Arnett at my far left. On my immediate right is Lowell Arye. Also with me is T. J. Seibenman and Bob Hagadorn. I might say that there might be a couple of you that might want to say something to me about a personal matter, such as social security, and Bob, if you will raise your hand, feel free to talk with him because he is our staff director here in Missouri. His office is in Blue Springs and it might save us just a bit of time sometime this afternoon before we leave.

At this time, I call the first panel: Mrs. Clary, Mrs. McFarland, Mr. Bradshaw, Mrs. Kuper.

I will recommend—and I will without objection—request that the prepared testimony of the witnesses be inserted in the record exactly as you prepared it but that you summarize your testimony so that it will leave a few more minutes for Congressman Daub and me to ask questions, and that would probably be the best procedure. We will begin our comments from Mrs. Clary.

PANEL ONE, CONSISTING OF MARY FRANCES CLARY, DIRECTOR, RETIRED SENIOR VOLUNTEER PROGRAM, CLINTON, MO.; GRACE McFARLAND, MARSHALL, MO.; HAROLD BRADSHAW, CHAIRMAN, HENRY COUNTY COUNCIL ON AGING, CLINTON, MO.; AND ELBERTA KUPER, CENTERVILLE, MO.

STATEMENT OF MARY FRANCES CLARY

Mrs. CLARY. When preparations were being made for the 1971 White House Conference on Aging, I was involved in some of the group meetings and discussions which were held here in Clinton. That was before anyone had thought of the retired senior volunteer program and many of the other programs which were supposed to lead to the better life for older adults.

It seems to me, as I look back through the years, the name, White House Conference on Aging, was really a misnomer. It should have been White House Conference on the Aged because most of the recommendations coming out of the conference did not deal with aging but with those people who had reached a certain age; 60 seemed to be the magic number if one wanted to benefit from many of the programs evolving from the 1971 conference. And the same seems to be true if one looks at the results of the 1981 conference.

The thing that I remember most from my involvement in the 1971 conference preparation, and what I believed was a high priority was, if we had enough money, we could take care of ourselves. It seemed to me that this was interpreted as asking for a handout.

And that is exactly what they were offered. With the passage of the Older Americans Act, many programs were started: transportation, nutrition, information and referral, supportive services, volunteer programs, employment training, et cetera.

Here in Henry County and in all 13 counties of district 3, we have an excellent record as far as establishment and management of all of these programs. And many older adults have benefited from the programs. Life has been more meaningful because of the presence of the senior center. Nutrition needs have been met by

the nutrition components in most of the centers and the companion good health has been appreciated and some of the participants have enjoyed the social activities. One did not have to get out of bed in the morning, looking forward to nothing but loneliness. Those receiving meals delivered 5 days a week also had something to look forward to. Subsidized transportation on the OATS bus solved many problems for lonely, isolated people. And the other programs were just as effective. Those programs made it possible for older persons to remain in their homes and enjoy their independence. Really a fine record and a great accomplishment.

But let's go back to that word "aging." What are we going to do about that? How do we interpret preretirement planning? Can it be included under the Older Americans Act? In order to plan, we must be educated. Where do we start?

Recently, in southern Missouri, a survey was conducted by members of the task force on aging of the Missouri Catholic Conference Social Concerns Department. The survey sought to determine if the subject of aging was included in any subjects taught in the schools. Both public and private schools were contacted and the answer was negative in all instances. The concern was there but the curriculum lacked reference to the subject.

Aging-related subjects should be taught and I think it should be taught in our schools. This cannot be accomplished overnight; great care should be exercised in developing such a curriculum.

The elementary and secondary schools would be ideal places to start educating individuals so that they can understand the aging process as it relates to themselves, and the accompanying problems.

Universities might offer adult education subjects relative to preretirement planning and I believe that this is already being done. Social security seems to be the preretirement planning most folks do.

The Social Security Administration could do much to educate persons about the importance of preretirement planning. Since all people in the United States have social security cards, contact could be made and involvement in such training could be encouraged.

Television is an excellent media for reaching persons of all ages and could be the means for education for planning for retirement. Stimulating and motivating middle aged persons to become interested in preretirement planning is a goal which is very challenging and, I hope, achievable.

President Kennedy once said: "It is not enough to add new years to life; our objective must be to add new life to those years." We can do that by preretirement planning. I congratulate this committee for considering this very complex subject.

STATEMENT OF GRACE McFARLAND

My name is Grace McFarland, age 77 years, 992 West Thomas Street, Marshall, Mo. I am a foster grandparent. First, I want to emphasize my love for my country. It is the best land on Earth. Our Constitution is one of the finest articles of Government, guar-

anteeing freedom of religion and other inalienable rights. What price freedom.

Now, I feel there are so many ways in which we can improve conditions as they exist today. Crime and drugs is our worst enemy, and should be punished more severely. Police bring in criminals and the judges turn them loose. Elderly people are hard hit, are afraid to get outside their door, or to go to the grocery store. They keep their houses locked tight and some have smothered to death because they were afraid to open a window. They are even being raped and beaten in their own homes.

Lawyers draw the laws upon and leave loopholes so they can get their clients out. Offenders are put in jail overnight or a few days and then let loose and out on the prowl again.

Another item is the tax situation. Sales tax is the only fair tax there is. Property tax is very unfair. The young adult is having to pay so much out for tax to keep all the rest fed when some need it and some don't. There are people on welfare able to work who won't when they could for fear their welfare will be taken away. I believe there should be some way of Government subsidizing a man so he could work and help keep himself. I don't ever want to see anyone going hungry, but we should all be willing to work for a reasonable wage. I do believe there is too much waste in Government.

The Government must come to the aid of the elderly in regards to gas, electricity, and telephone. We have to keep warm in the winter and we need electricity for so many things. The telephone is a must for protection. We are on fixed incomes, yet get sick like anyone else. The doctor, medical, and hospital bills are so high and we can't afford insurance to pay them. Many times it is a question of eating what we need or paying these necessary bills. We need clothing, transportation, eyeglasses, and dental work. Something must be done to stem the tide of rising costs, perhaps price controls. If something isn't done about the price of food, low-income people will suffer.

Education—how in the world did so many teachers get in our schools that can't teach reading, writing, and arithmetic? Teachers should be screened and good. I think its about time we go back to the old way of teaching reading, writing, and arithmetic. Now, I'm not saying that all teachers are like this, but there are all too many that are and it hurts. A really smart, bright child can get a teacher like that and they get behind and stay behind until they get disinterested and it hurts. I think there should be something done to take care of this situation. We have a lot of wonderful teachers who have worked and earned their title. If I were young again, I would work, save my money, and make it through school.

Tips for the elderly—don't worry about getting old. It is a natural thing and if we don't die, we all get there, it's as simple as that. And you notice it when you start feeling sorry for yourself. As long as you can get up, get out, and keep busy doing something, maybe for someone else, it will make you feel better and you will just forget about getting old.

Don't let strangers in your door. My neighbor, 86, let one in. He was supposed to be a termite-control man. He made the investigation for free; and he walked off with $300 and she never saw him

again. She didn't have any information on him at all and there was nothing anyone could do to get her money back. Remember, there are all kinds of fraud and it looks promising. You have good friends, you know them, ask them, or your clergy, and don't ever trust a stranger about anything. She was afraid of having "turtlemites" as she called them.

I'm in favor of the Government giving assistance to the low-income elderly to keep them in their homes as long as they can and it would be cheaper than keeping them in nursing homes.

Now I have a few tips for all us elderly or older people.

Self-control and credit cards—our appetite for anything harmful to our well-being. Our temper—it can cause us lots of trouble, nervousness, heart trouble, et cetera. Our habit of bad talk or taking God's name in vain. Attitudes toward other people and things. We all have a right to our own opinion of anything.

I'm not in favor of credit cards. I think it has ruined a lot of young people and some older people. They spend too much and then end up in such deep debt they can't get out. I think it should be outlawed or discouraged.

Thought life—if we can control our thoughts and think on these things, we will be happy: First, things that are honest; second, things that are just; third, things that are pure; fourth, things that are lovely.

I appreciate this opportunity to testify.

STATEMENT OF HAROLD BRADSHAW

Mr. BRADSHAW. I am not going into detail on this, although the testimony I have relates to various phases of the economics on aging and I present an actual case which covers several of those phases.

This particular female of 77 years started teaching in a country school down here in the hills. Later worked for two tobacco firms in the East, then worked for a brokerage firm until retirement at age 62. She had fallen on an icy sidewalk and broke her back, and later developed osteoporosis of the spine. At no time did this woman make $600 a month. But in that time, she was able to accumulate approximately $10,000, and I think most of that was done when she was working at the brokerage house.

When she retired her social security amounted to $249 a month and was later increased to $383. Keep that in mind.

Last February, she entered a hospital for a break of four veterbrae in her back. Later tests showed the carotid artery, left and right, had blockage. After sufficient recovery, she was placed by a doctor in a nursing home.

I'm not going into details on this because in that statement I gave you, she went through $10,000 in 8 months; $8,124 for care, $653 for medicine, $973 for tests and her hospital not covered by medicare was $239. And $18 for a second opinion on a particular phase.

At the time of discharge, she had used up $10,008 of her savings, plus accumulated social security from March to September.

Now, this is all set out here; $383, she has $60 too much for medicaid. She can't get medicaid. She had less than $500 in the bank at

the present time. And the doctor discharged her to attempt to live at home which, evidently, the Government is trying desperately to get people to live at home if they possibly can.

She was discharged September 30, so $60 is too much for medicaid and the only way she can get medicaid is to go back to the nursing home. And going back to the nursing home, she loses her Blue Cross and Blue Shield, which costs $74.76 each 2 months. So we have a 77-year-old woman, weighing 90 pounds, sitting alone, worrying because all her money is gone and she doesn't know what is to become of her.

Last night, she broke her right hip. She's in the hospital. They are repairing that now. When she gets out of there, she will have to go to a nursing home and start all over.

Thank you, gentlemen.

[The prepared statement of Harold Bradshaw follows:]

PREPARED STATEMENT OF HAROLD BRADSHAW, CHAIRMAN, HENRY COUNTY COUNCIL ON AGING, CLINTON, MO.

Gentlemen, in compliance with your request for testimony relating to the various phases of the economics of aging, I present an actual case which covers several of the phases.

The case in point covers a female age 77. She started teaching in a country school, later worked for two tobacco firms in the east then worked for a brokerage firm until retirement at age 62 account of health. She had fallen on an icy sidewalk and broke her back, this later developed into osteoporosis of the spine. At no time in her working life did her salary amount to as much as $600.00 per month. Her Social Security amounted to $249.00 per month to start, various increases brought it up to the present level of $383.00. By strict economy she was able to accumulate nearly $10,000.00 over her working life.

Last February she entered the hospital for an additional break of four vertebras in her back and by later tests found to have blockage of the Carotid artery right and left. After sufficient recovery was placed in a nursing home by her doctor. From the time of entry, March 4th, to the nursing home, to discharge September 1st, she was billed $8,124.75 for care, $653.64 for medicine, $973.50 for tests at the Clinic. Hospital room not covered by Medicare in the hospital $239.00 and $18.00 for a second opinion from another physician on one particular phase.

The physician who discharged her did so to try her out on living alone. At the time of her discharge she had used up $10,008 of her savings plus the accumulated Social Security, from March to September.

She was able to hold onto her apartment for one month when she went to the hospital, rent $54.00. When she could not return to the apartment it was necessary to pack and store her furniture, cost $266.00, storage and insurance $21.36 per month then to have her furniture moved to an apartment, in subsidized housing, $94.00, deposit $50.00, rent $52.00 which left her with less than $500.00. Since then she has received bills of $36.00 from the nursing home, $21.00 from the clinic and $33.00 from the pharmacy, that should be all of her outstanding bills. After her discharge from the hospital to the nursing home she paid all of her bills. No help from any source.

Now if she has to return to a nursing home she would have to apply for medicaid. That would mean that she would have go give up her Blue Cross and Blue Shield then if she would ever be able to leave the nursing home she would never be able to pick up her hospitalization again.

On Social Security of $383.00 her expenses would be rent $52.00, gas and electricity average $45.00, telephone $8.50, medicine $56.00, checkup by doctor $15.00, hospitalizations insurance $74.76, for two months that would leave about $175.00 for food, clothing and any emergency that might come up.

One of the strange things the nursing home does is, when a patient is transferred to the nursing home, the clinic pharmacy automatically puts 30 day supply of medicine the patient has been using in the hospital to the pharmacy in the nursing home. In this case it amounted to $157.00 worth. Another peculiar item is, while this lady went to Lowry City Nursing Home for three weeks and did not like it, she bought a flotation mattress, cost $9.00. She brought it to Clinton when she came back, this was in June, on her August bill there was an item of $31.00. When they

were asked the bookkeeper said it was rental for a flotation mattress. The reason given was that these mattresses were sent to the laundry and often had to be replaced. If that is so, why wasn't it on her July bill as well? This lady states that during July and August she made her own bed and at no time was a new flotation mattress installed.

Here is a case where the lady attempted to be financially prepared, her Social Security is $60.00 above the health care alternative people would normally turn to, she knows of no other available resource. So we have a 77 year old, 90 pound woman sitting at home worrying because all of her money is gone and she does not know what is to become of her.

Last night she fell and broke her hip and is back in the hospital.

STATEMENT OF ELBERTA KUPER

Ms. KUPER. I will try not to read this but I will use it as notes.

My name is Elberta Kuper and I am 71 years old and I live on the rural route of Centerview, Mo. I am currently employed with the Johnson County Community Health as a homemaker coordinator and I'd like to say this is a very rewarding position to be in to be able to help senior citizens and those that are really in need.

I was married to Roy Kuper for 47 years. We lived part of the time on a farm and part of the time we had a construction business, which we both contributed our services. The IRS, of course, treated us as one and our taxes were paid as one individual. However, social security treated us as two separate individuals.

Now, as my husband was older than I and he had to retire because of ill health—he retired at 62—his social security was less than mine. At the present time, my social security is $381 a month. My husband's, of course, was less than mine.

I would like to cite an incident in a book that we have called "Estimating Your Social Security Retirement Check."

Couple A: Both husband and wife drawing social security on their own work record, which is comparable to my husband and I. We both worked. Each have an average earning of $4,000. Therefore, their entire household earnings are $8,000. At age 65, each will draw $296.20 per month, for a total of $592.40, total income.

Couple B: Only one spouse has been a wage earner covered by social security. His annual income is $8,000. The contribution is the same as couple A. However, when they reach 65, their benefits are much larger than couple A.

Using the same pamphlet, a wage—earner with $8,000 average income would receive a payment of $482.60, and the spouse, having made no contributions to the program will receive $241.30. Couple B will receive household social security of $723.90.

Using the two couples, when both husbands are deceased, the widow in couple A will receive her monthly payment of $296.20. And the widow in couple B will receive $482.60.

Now, this is my question: When two people work and they both pay in and their earnings are the same as a one wage earner, why does the family with the one wage earner receive more benefits than with the two wage earners?

I would like to make a suggestion. Since the IRS treats you as one person, one individual account, why should not the social security of the two people, one wage earner be applied equally to the four social security numbers? Then when the spouses are deceased, each widow would receive her fair share.

With the plan that we now have, at the age of 65, or at the death of the one spouse, the widow of the one wage earner, this widow will be receiving more than the widow of the spouse where they have both worked.

And, to me, this doesn't seem fair that we have two wage earners in one family and one in another and, yet, there seems to be a reason, for some reason, that the one widow is given more than the other widow. In other words, she receives as an inheritance, her husband's social security, where couple A's widow does not.

Thank you, gentlemen, for letting me testify. This has been a sore spot with me for a long time. There are a lot of things that we, as senior citizens, like to have and a lot of things we like to do for other people but sometimes our social security doesn't go that far. So I think it's our privilege, if we prefer to continue to work so that we can do these things for other people, I don't think we should be deprived from something that other people receive when they stay at home.

Thank you.

[The prepared statement of Ms. Kuper follows:]

PREPARED STATEMENT OF ELBERTA KUPER

My name is Elburta Kuper. I am 71 years old and live at Rural Route #1, Centerview, Missouri 64019.

I am currently employed with Johnson County Community Health as a Homemaker coordinator.

The problem I wish to address deals with Social Security. I am currently receiving Social Security based upon my own work record of $381 per month.

I was married for 47 years to Roy Kuper. He died in 1976. During the 47 year marriage we worked as a team, each of us contributing equally to the up-keep of our home and the rearing of our children. Sometimes he making more but all monies going into the joint bank account and spent for necessities of the family.

The Social Security Administration, however, treated our social security accounts as if we were each single individuals crediting each of our accounts with the contributions paid on our individual salaries.

During several years of the marriage we lived on a farm and/or we owned our own construction business. During that period the Social Security contribution all went toward my husband's account, even though the profits from the business was our joint effort.

Inasmuch as my husband was older than I and his health failed during the later years of our pre-retirement my wages were larger and consequently my Social Security contributions were larger than my husbands.

When retirement time came my Social Security check was slightly larger than his inasmuch as my payment was based on age 65 and due to ill health he had had to retire at 62.

If all of the wages that were paid in by our household had of been credited to one Social Security account, as it is in those families with one wage earner, the amount payable on that account plus the ½ of the benefit payable to the spouse, would have been much greater than the amount we received.

Using the Social Security Administration Publication No. 05-10088 (January 1983) pamphlet entitled "Estimating your Social Security Retirement Check", I use the following example:

COUPLE A

Both husband and wife draw Social Security on their own work record. Each have average annual earnings of $4,000. Therefore, their household has paid on an average of $8,000 per year. At age 65 each would receive $296.20 per month for a total of $592.40 household income.

COUPLE B

Only one spouse has been a wage earner covered by Social Security. If his average annual income is $8,000, this family's Social Security contribution would be the same as Couple A. However, when they reached 65 their benefits were considerably larger. Using the same pamphlet, a wage earner with $8,000 average income would receive a payment of $482.60 and the spouse, having made no contributions to the program, would receive a monthly payment of $241.30. Couple B would receive a household Social Security payment of $723.90.

Using the hypothetical couples above, couple A being very similar to my own situation, when both husbands are deceased the widow of couple A will receive a monthly payment of $296.20 and the widow in couple B will receive $482.60.

My question to you Congressman is "when both couples have contributed the same amount to the program why does couple B receive $131.50 more per month in benefits than couple A while both are living and widow B receives $186.40 more than widow A after their husband's are deceased?

My suggestion to remedy this inequity is that the combined contributions made by both parties of a marriage be credited to their joint account and in turn each be entitled to benefits based on ½ of that joint account. There would be no additional widow's benefit under this plan.

This plan would also eliminate the situation where a person married to a number of different wage-earners for the specified length of time (10 years or at death) can choose which deceased spouse's Social Security benefit she wishes to draw on. Under the plan I have suggested an individual's annual contribution would be figured on ½ of the combined earnings of the husband and wife for each year they were married. This system would be similar to the joint income tax plan for married couples.

I see other widows who have never worked under Social Security drawing twice as much Social Security as I do. I know women who have their choice of as many as three former husbands of which they can choose the higher Social Security payment. Why do these women receive benefits from their deceased husband's accounts and I get no credit for the many years my husband contributed to Social Security?

Realizing that the money in the Social Security trust funds is limited any bonus given one segment of the population must be taken from the benefits of another, I resent the fact tht the 1 wage-earner couple receives far greater monthly benefits and twice as much Medicare coverage in ratio to the money paid in as the 2 wage earner-couple does.

I thank you for the opportunity to present my views and opinions and will answer any questions to the best of my ability.

Mr. SKELTON. You see why we're here? To hear these problems and I just leaned over and told my friend, Congressman Daub, this is really hearing from America. You know, we often turn the television on, you listen to radio, you read in the newspaper that such and such happened in Washington, D.C. Well, let me tell you right now, rural America is right here and what we do in Washington, hopefully, reflects the good and best of our intentions and here in the heartland of America, so we do appreciate your being with us.

I will ask in just a minute our friend from Nebraska if he has some questions. I can't help but comment, Mrs. McFarland, on your closing remarks where, if my memory serves me correct, Paul's letter to the Philippians—I think it's the 4th chapter—wherein, he wrote to the Philippians whatsoever things are honest, whatsoever things are just, whatsoever things are pure, whatsoever things are lovely, if there be any virtue and if there be any praise, think on these things and it's so important what we think. And I think that's probably one of the best pieces of teaching of all times and I appreciate your mentioning that to us.

Congressman Daub.

Mr. DAUB. I enjoyed the testimony very much and I think it is clear that you took time to prepare yourselves to give us an accurate point of view. I think what you said is reflective of a lot of feelings and you summarized those well. Mrs. McFarland, you did

take a shot at lawyers and both Ike and I are going to have to plead guilty to that. We understand that we are one of those types of animals. Yet the credit card thing—as you mentioned—probably is a story that has not been recognized by America. We have considerable personal debt accumulated because it's so easy. We're so impatient, we want it yesterday, and we're going to use our plastic to get it tomorrow. I start to wonder if the government ought to ban credit cards.

Ms. MCFARLAND. I think they out to be outlawed.

Mr. DAUB. But the point is, we don't want our Federal central system to be interfering with those kinds of things and telling us what we can and can't do from the cradle to the grave. You quoted the Bible. Well, I will tell you that I think when the Lord put us on this Earth he didn't say it was going to be easy. We're supposed to use our heads because the gate is pretty narrow. So I don't think the Federal system ought to get involved in banning credit cards. The point is that educating people about their dangers is something I think we ought to spend more time doing.

Let me ask a question of Mary. You talked about the first White House Conference. We have had two White House Conferences now.

Were you trying to say something else when you made the distinction between aged and aging, saying that maybe we deal with people's problems once they get old but you forget to help us deal with our problems before we get old.

Mrs. CLARY. Help prepare us for them.

Mr. DAUB. Is that what you were trying to say?

Mrs. CLARY. Right.

Mr. DAUB. I appreciate that very much because that is a good point.

I want to conclude my comments to this panel in a question. Let me answer your question, Alberta, if I can. I am not sure I can, but I will try.

You can't just say that since couple A and couple B, have the same gross income in the year in which they retire they ought to get the same benefits. The social security entitlement or the benefit itself, is, and always has been calculated, based on three things. These three things include the contribution to social security, or the contribution of both the worker and the employer if they were not self-employed, the wage level and finally the cost of living increase, which is the automatic index for inflation each year. It is the second item, the wage level, that makes these two cases different. The average of the highest 60 months may be different on both tables. Perhaps they have worked longer, had higher incomes or lower incomes than the other family and paid in different amounts. Because the table is based upon these averages and the high 5 years or 60 months, they may be a different. At times, the contribution of the one-half employer, one-half employee may have been higher or lower. It's very conceivable that these two entitlements should be different because one paid in more than the other. That's the only reason why they are different and I know what also strikes people sometimes as unfair is when the surviving spouse, which up until now has normally been the woman, sees her table raised only a little bit if her husband should prematurely passed

away. He has paid into the system at a higher rate all those years, yet she doesn't get the benefit of that.

I want to give you some good news. In the Social Security Reform Act that Congressman Skelton and I voted for the ninth provision of the compromise was to raise the benefits, starting January 1, for the widowed and single female. Those benefit tables are going to increase. The reason for this increase is that up until now, most of the credits for social security have been male credits. Although we're starting to see more women in the work force, it is still not going to average out until about 20 years from now. I think some changes have been made that solve part of the problem you point out and thank you all very much for your fine contribution to our record today.

Mr. SKELTON. Thank you very, very much.

Would the second panel please step forward, Mr. and Mrs. Porter, Mrs. Mikels, and Mrs. Taylor.

While these folks are coming forward, I want to pay special thanks to our friend, Alice Jones, who is the director of the Foster Grandparents program and a long, long time friend of mine. Thank you for assisting us in our hearing today and helping us get witnesses. I would like to thank those who have been alternates, who, should some of these witnesses not be able to testify, have made themselves available, Mrs. Leona Carter, Mrs. Selma Rinne, and Mrs. Ethyl Stowell.

Mrs. Porter has just given her time to her husband and Mr. and Mrs. Porter have been friends of mine for a long time and I must say that's a first, isn't it, Leo?

Mrs. Rinne, if you have some comments, you may join us today because Mrs. Porter has given her time. Or if you have some written testimony, we will be glad to receive it and put it in the record.

PANEL TWO, CONSISTING OF LEO PORTER, CHAIRMAN, BENTON COUNTY COUNCIL ON AGING; ETHEL MIKELS, FOSTER GRANDMOTHER, MARSHALL, MO.; JULIA TAYLOR, MARSHALL, MO.; AND SELMA RINNE, HIGGONSVILLER, MO.

STATEMENT OF LEO PORTER

Mr. PORTER. It is a pleasure to report my findings to this committee for Benton County.

Mr. SKELTON. Let me interrupt just a moment. Tell Congressman Daub the position you hold in Benton County relating to senior citizens, please?

Mr. PORTER. I am cochairman, along with Dorothy, for Ike Skelton's senior citizens in that county and I am chairman of the Benton County Council on Aging, and that takes care of the nutrition sites, et cetera.

We have some 3,000-plus people in Benton County, of the 12,000 census, that are over 60 years of age. Now, you've quoted some percentages awhile ago, but down in Benton County, about 33 percent of them are over 60 years of age.

I did submit to our once-a-week paper to all of Benton County to send me suggestions and complaints and also from the Benton County Council, I asked for their suggestions, likes, dislikes, whatever. However, it was no surprise to me that after about 2 weeks, I

only received two small letters. Now, these people are survivors. Down in my country, they will live through anything that happens between now and eternity without griping or grouching. I actually believe that most of them would starve to death before they would go next door and ask for a crust of bread. Very proud people.

However, due to some experiences—and I am going to make this in general statements because I have some statistics to bring forth—but without exception, I think most of the complaints have to do with medicare. Now, most of the people recognize that the medicare program is the most beautiful thing they've ever seen. However, to a person, they complain about overcharging, duplicate charging and having to take examinations that they can't see any reason in the world for.

The last prime example I have of that is the lady that was in for a 1 week's stay. After she was in the hospital about 3 days, they found out what her complaint was that she had to go to the hospital for. However, she had to spend another 3 days with CAT scans, bone scans and urinalysis, GI's, various other examinations that had nothing to do in the world with what was her ailment.

In other words, you go in there with an ingrown toenail and you go through all of these examinations. And you wonder why the old people are so stupid as to allow this. But you take a person 75, the old lady goes in a wheelchair and she's in so much pain, she would sign her life away to any document that's shown her at the entrance desk. And you have to go through the entrance desk or you don't get into the hospital. That's all there is to that. Unless you're breathing your last breath, you got to sign in down at the entrance desk in the wheelchair and in pain. And the old man, he's so stupid, he'd sign anything, so they wind up signing these release sheets that allows the hospital to go through this whole series of every piece of equipment they have in the hospital. I know they are expensive and they have to be paid for.

But the main question the people have to ask is why? And the answer is, of course, malpractice suits. If they fail to find something while you're there, then when you leave and you come down with a serious ailment, then there is a malpractice suit with the high price of malpractice insurance.

I have no way of proving any of this. It is strictly by word of mouth of the individual that have had the experiences. They get duplicate charges. The first week they are out of the hospital, they get a computer readout as to what you have had done and what you own. Generally it states down at the bottom, regardless of what the insurance pays for, you owe this amount.

Now, older people like I am talking about, they want to keep their bills paid so they will sit down and write a check for that amount. Next week, they get another set. It says you owe this much with no regard of what the insurance has paid. It's easy for them to write another check, especially if they've got a couple of thousand dollars in the bank because they know their insurance won't pay.

So I have a feeling from this, and maybe you already have a feeling, too, that somewhere here the fox is in the chicken coop. I do know the Government has many ways of investigating this and the complaint of the people is why don't the Federal Government

police this more seriously? You may tell me in a minute that they are doing the best they can, I don't know.

Several people feel that the medicare thing should be extended to other things than what is now. One of them I'm sure Ike is working on now, that you're already working on, optical aid and other people can't understand why you can't buy hearing aids and teeth to eat with. And I think probably the answer to that, and we know we have to see to get around. If we can't have good dentures, maybe we can gum it; I don't know.

In closing, I've never seen a time when old people have been infringed upon so and taken advantage of at almost every angle. Take an older person into a store and they can't read good and they have some clerk or manager helping her, they can go to the highest bottle of catsup here for $1.89 and they've got the black and white bottle over here for $1.29. If you think the manager is going to give her the $1.29, then you're foolish. And the manager would be foolish because he's in this thing to make money. They are taken advantage of in the store.

Another thing is this high-pressure selling of supplementary insurance. So many of them are being endorsed by our friend, Danny Thomas, and in his endorsement, he says, "I'm glad to be paying for this endorsement for this company." He doesn't say he's got it. But he's proud to endorse this insurance.

Mr. SKELTON. Let me stop you right there. The majority staff member has a comment on this.

Mr. ARYE. At this point in time, the staff director and I have begun to investigate what is called the medigap insurance—private insurance plans to supplement medicare benefits—and that is exactly what you're speaking about. We also are concerned that celebrities such as Loren Greene and Art Linkletter are endorsing these plans which may take more money out of the elderly's pockets. We are planning to examine these plans in the near future. So what you're bringing up right now is of concern to the staff.

Mr. PORTER. You just saved yourself about 5 minutes of conversation.

In closing, the natural question, of course, is why are old people so stupid, as to let these things happen? This is something all of you younger people should be concerned about because if you're lucky, you're going to be faced with the same problem, which can easily become much worse.

Thank you.

[The prepared statement of Mr. Porter follows:]

PREPARED STATEMENT OF LEO PORTER

Mr. Chairman and Honorable Members: It is my pleasure to report to you of my findings in regard to Economic Problems of the aging of Benton County.

After asking for input in the form of complaints or suggestions that I could present to this committee for their consideration, with regard to the psychological changes, financial preparedness, health care alternatives, and available resources.

I asked for help from the Benton County Council on Aging, also I had an item released through our local media, asking the people of Benton County to send in suggestions or complaints that could be used by you in your work.

There is some 3,000 plus people in Benton County over the age of 60 years.

It came as no surprise to me, but I received very little response. These people are highly independent and full of pride, largely rural and small town, most of them I'm sure would rather starve than to accept or even hint they needed help, and to

ask for anything that hinted of charity. It would be out of the question. I did however get the feeling that most of them feel that Medicare is absoutely wonderful, but nearly all of them I talked to feel that the Hospitals & Doctors are over charging, duplicate charging and worst of all feeling that they have examinations forced upon them they absolutely do not need. This seems highly unlikely but many old people upon entering a Hospital are asked to sign papers as they are entering, releasing the hospital of any and all responsibility and gives them permission to use every piece of equipment in the hospital to determine the patients problem. Many of these old people enter a hospital on their own, with no children or advisors and in their pain or discomfort will sign anything they are asked to. This allows the hospital to give Upper & Lower G.I. Series, Urinary, Kidney exams, Bone Scans, etc., even though the patient might have only in-grown toe nails or something as simple.

They wonder why the Government doesn't police this handling closer.

I'm sorry these statements have to be general in nature because I have no way of investigating or documenting them with proof. However, I'm sure the Government has all the means necessary to check these out. Most of the bookkeeping and billing is done by compute and statements itemizing charges are sent out at regular intervals after the patient is released at least within a week. All of them giving the amount due to be paid, people desiring to get their bills paid as soon as possible could easily pay the same bill one or more times. The hospital is quick to assure them if they overpay their money will be cheerfully refunded.

Several people feel that Optical, Dental and Hearing expenses should be taken care of by Medicare. One lady was telling that she has to go to the Doctor every 3 to 6 months to be told her eyes are OK, to come back in 3 to 6 months to be checked again. This costs her $35 to $55. Another person needing Dentures has had to use old ones because they just could not afford new ones. One man is using an eight year old Hearing Aid that hardly works because he can't afford to buy a new one.

In closing I must say I have never seen a time when old people have been so pressurized and taken advantage of through High-Pressure selling and scare tactics in selling to them Insurance and some of it is absolutely worthless. The use of Commercials using people such as Danny Thomas, Loren Green, Art Linkletter, Arthur Godfrey and many others is cruel to, many of the older people. These people are like Saints and can't possibly do wrong. A Doctor we had in Warsaw was released because he wasn't referring enough patients to the hospital, the reason given for his release was he would do better in private practice.

It is also rumored that Doctors get a $50 kick-back for each patient referred to a hospital. No proof, no smoking gun, but as the saying goes where there is Smoke, There could be fire.

The natural question is of course, why are old people so stupid as to let these things happen? This is something all younger people should be very concerned about because if they are lucky they to, will be faced with these same problems, which can easily become much worse.

STATEMENT OF ETHEL MIKELS

Mrs. MIKELS. I am Ethel Mikels and I am from Marshall. I am past 79 years. I have been a foster grandmother for Marshall State School and Hospital for about 8½ years. I really love it.

My father was a farmer near Slater for several years and then later, we moved to another farm, also near Slater. I was reared in a family of five girls, no boys. My father worked hard and we girls were expected to help with anything that we could around the house. We helped with housework, churned butter, gathered eggs, and we helped with meals. We use coal oil lamps and we pumped water from a well for household use. My mother made all our clothes and I guess we looked as nice as any of the other neighborhood children, who went to the little country school, where 30 or 35 other kids attended. We were a happy family.

Now that I'm older, I am concerned with present-day problems. I think it's only natural for people, as they grow older, to think how they will manage in later years. This is the time when we have

health and financial worries. As soon as they can, they should get legal advice and get their property in order.

Mr. SKELTON. May I interrupt you for a moment? Two of our staff members are leaving to fly back to Washington and they've done literally weeks of work. Congressman Daub and I will stay to hear the balance of the testimony because Congressman Daub doesn't have to catch an airplane for a few more minutes.

Mrs. MIKELS. Inflation is a big topic of conversation today. Prices on everything are too high and this is something we all know but nobody can do anything about.

Social security is such a big help to all who are eligible. I think it's one of the best things that has ever been done for us. What would we do without our monthly checks?

I know there are many problems in the system but I don't believe the problems are any worse in this system than any other place. Those who are eligible have paid in for years, so they deserve to have it. I know our wage-earning children have to have dollars taken our of their checks every payday and that's sad but because they have growing families and children in school, and they need it. But this is the source of social security funds and they have to hope that they will live to someday get theirs. I am so happy to be in America and enjoy getting my check each month.

There are several other concerns of low-income and other people in this United States. Some concerns are medicare, high hospital costs, doctor bills, increase in fuel and telephone bills and especially the high cost of food. Doctors and hospital charges are extremely high. Medicare does not pay as much for things as they used to and this is because the doctors' charges are too high and medicare won't allow it. Every few months, they raise their prices, the doctors raise their prices.

It's the same about drugs people have to have. Prescriptions are very high and I expect many people neglect their health because they just don't have the money to buy what the doctors prescribe. The Government could look into this problem.

Along this line, there are other areas that I would like to see get some help from medicare. I'd like to see low-income adults get some help with eye problems, surgery and glasses. This would be a big help.

Another area which needs help is dental work, dentures. Both are problems connected with health and need consideration.

Medicare is a great help, also, but it doesn't allow as much as they used to. I realize this is partly due to doctors and hospital costs. There has to be a way to control the high prices they charge. I'm hoping this new plan they are talking about will help.

The tie-in plan of the insurance companies, they help; Blue Cross/Blue Shield, they help some but even that isn't enough, considering the premiums we have to pay. Another comment is the paperwork we have to have after a stay in the hospital. That's very hard for older people to work problems out. When the checks for medicare come in, the patient has to fill out another form and send an explanation back before Blue Shield will send the money.

I do not have any solutions to these problems but I wish they didn't exist. I think we need time and wise, honest people who care to get things back on the track. In my family, we were happy to

have social security and medicare for they were a blessing to our family when a few years ago, my husband had to have acute, emergency surgery. It was wonderful and makes me so happy to live in America and to be able to receive such benefits. No where else in this world could we be so lucky.

Thank you.

[The prepared statement of Mrs. Mikels follows:]

PREPARED STATEMENT OF ETHEL MIKELS

I think it is only natural for people who are growing older to be concerned about how they can manage in their latter years. This is the time when health problems arise and financial worries develop. They are limited on funds to keep their bills paid, and they can't solve the problems that confront them. Inflation is a big problem for every one. It is this time in our life when we hear about Social Security, Medicare, high hospital costs, doctor bills, food prices, eye problems, dental bills, telephone bills just to mention a few of their worries.

These are mostly the same people who have lived thru the deep depression days and they know, from experience, what its like.

All doctors and their assistants charge extremely high prices, Medicare doesn't allow even as much as they once did, and the tie-in insurance plans help some but they too have problems. I think, if you have tie-in insurance like Blue Cross-Blue Shield they should receive the explanation of Benefit from Medicare and send the amount they owe the patient right away. Instead they send EOB papers to the patient who then has to fill out the form and send back to Blue Cross-Blue Shield. After all this is finished the patient may receive what is due them. These tie-in insurance plans need looking into. They are very high in price and go up real ofter.

However, I'd like to say a good word about Medicare doing a good job in many cases. We had experience two years ago when my husband had emergency surgery. We were pleased with what they did for us then, and the speed in which it took.

I would like to see some aid given thru Medicare to people who have eye surgery. This is an area which would benefit many people. It, and some dental help would be wonderful. Many people delay going to take care of their eyes and teeth because it costs so much.

Another big problem for every one, not only the elderly is the high cost of food. I just can't believe that prices on foods need to be marked up almost every day or two like you see going on in the stores. We all have to have food not only the old population, but the young with growing families. I don't see how, they manage. I know the stores have high bills too, but they don't seem to be able to do any different. The food stores are just like the hospitals they raise their prices any time. There isn't any one to stop them. I think there should be controls on them. I wonder if the government could freeze their prices at a certain time without the news getting to them before they could, up their prices.

I'm really happy that we have Social Security. There are lots of problems with-in the system, but it helps so many. Lots of people couldn't do without their social security checks. I know large sums have to come out of our childrens cash earnings, but I hope we will always have social security checks. What would we do without Social Security? It provides the money so we can have better living conditions and more peace of mind. When I was a little girl I lived in the country and I was happy as any little girl could be. We pumped our water into a bucket from a well out in the yard, we were five little girls and our mother and father. The parents both worked hard every day while we girls played, after we finished our own daily tasks. Today, the children have nothing to do and the parents work out all day. This is not too good but its the way it has to be. It didn't take much to entertain us in those bygone days but we were happy as a family. We had to do without lots of things but then we didn't mind.

Much progress has been made in the last fifty or seventy-five years. Each person has his own ideas as to whether we are better off or not. I guess it depends on the person.

Mr. PORTER. Mr. Chairman, I would like to interrupt to let you know that Dorothy did submit a written testimony.

Mr. SKELTON. Let the record show that Dorothy Porter has submitted a written testimony and without objection it will be part of the record. Thank you so much.

[The prepared statement of Dorothy Parker follows:]

PREPARED STATEMENT OF DOROTHY PARKER

Most people of retirement age usually reach that time of life with no idea of what it means to retire. Most of their life has been working and paying bills and there never seems to be enough to save for anything. Most people have little or no savings and are afraid to spend for the necessities like teeth and hearing aids, also insurance. Old people are very vulnerable when it comes to buying and sales people take advantage of their lack of knowledge. Most supplementary insurance they pay for years, and when they need it, they find out it does not start until the 61 st. day. No one who has Medicare gets by with nothing to pay out of their own pockets.

Another problem with retiring is that with no money to spend to travel or shop or visit other places, there is a problem of keeping busy. So many people end up in a rocking chair and gradually become so weak they can't even walk. One of the most wonderful things that has ever happened to the elderly is the establishment of the Senior Centers. It is not just a place to eat and get a well-balanced meal, which in itself is really great, but they can see other people-make friends, and have lots of interest that they can follow, like music, dancing, painting, quilting, ceramics and sewing crafts, etc. On a daily basis these people, some who have no families, have a ready made family, who eat together daily, and learn to look forward each day to see the people they have learned to love. There is very little you can do to plan your life in retirement years because your circumstance change. People lose their spouse and like children, teens, middle aged people they need love. Just some one to care about what happens to them. They need God in their lives and a lot of them don't know God. They also need the Civil Authorities to care. When the government does not care about the elderly it makes the ordinary people unconcerned with their plight. People who are rich or well off financially have no problems, but everyone is not as fortunate as to be able to buy a house, or save money and so they depend on Social Security entirely to support them. God must have loved the poor because there are so many of them and please don't take the Nutrition Sites and Senior Centers away from them. That is all some of them have to look forward to. I have heard many young people say they can't wait to get old, because we seem to have so much fun. But just remember the fun is what you and I make it. My husband and I give many hours that is not required of us to plan and organize and help people. By helping others you also help yourselves. It keeps you younger, by your keeping busy. Please just don't forget our Senior Citizens, they need your love and concern.

God Bless You.

Mr. SKELTON. Mrs. Taylor.

STATEMENT OF JULIA TAYLOR

Mrs. TAYLOR. I'm Julia Taylor. I am 76 years old and I live in Marshall, Mo. I am not very good at speaking, so I will just read my testimony.

It is estimated in the year 2000, there will be 42 million Americans over the age of 65. We need to look forward and prepare for our elderly now and then, also.

The elderly may be living in a rundown neighborhood, where living conditions are deplorable and crime runs high, but on a limited income. There is nothing they can do about it.

Some may have children with whom they could live but would be very unhappy to give up their home and possessions. They would go through a very tramatic period, be very unhappy and depressed. They might go in a nursing home, except they are so expensive and where they would be very lonely, depressed and confused.

So we need funds now to take care of these people. Will there be social security? Will these people be heard? Will society recognize them as existing? Will there be race discrimination? Will there be programs available so they can be self-sufficient? Will they be able to feel useful and wanted?

Now is the time for more funds for housing, heat in the winter, utilities, especially the telephone to summon doctors, police, firemen, to check on other elderly or sick, to obtain food, medicine, et cetera. Much has been done on transportation, but we still need more funds for transportation. For medical social workers, homemakers and live-in companions, law care, legal services, jobs and programs to involve the elderly, like the Foster Grandparents program, and others. Without the Foster Grandparents program, I would be on the mercy of my children or on welfare. So I feel very fortunate I could get on the program. I am glad you have met our director and hope you can meet our coordinator.

Mr. SKELTON. What's your coordinator's name?

Mrs. TAYLOR. Rita——

Mr. SKELTON. Is she here?

Mrs. TAYLOR. Yes; the young adult barely earns enough to support his family. What about the senior citizens with much less earning power? Something must be done about the rising cost of living and something needs to be done about crime in the United States. Our tax dollars are being wasted, the criminal is being tried, judged insane and turned loose. Whenever he is sentenced, he is paroled in a few months and out on the street committing crime again. The elderly are afraid to go about their everyday living. They are keeping themselves barred in their homes because of the terrible crime. They suffer from isolation, loneliness, fear, depression, heat prostration and, in some instances, starving. And they don't have to be living in the ghetto.

Jobs must be provided. Unemployment and idleness is hurting our country. It affects the young, as well as the elderly. Jobs should be provided and a method of seeing that every able-bodied person works. The crime rate would go down, welfare would diminish, our social security system would be sound and our country would prosper.

I have a little note here on the notch. They said if you were drawing social security——

Mr. SKELTON. That's the item the Congressman is going to correct. That lady is wrong. I know that's a real concern and Congressman Daub has been in contact with "Dear Abby" on that, so we'll let him tell you about that. He'll explain that as soon as we're through with questions. Even "Dear Abby" makes a mistake.

Mrs. TAYLOR. The rehab programs run by the cities should be investigated. The elderly are being taken in lots of cases. Huge amounts of our tax dollars are being wasted. The contractor taking the job does not oversee his crew. He hires men without any skills and the work is poorly done. They put on new roofs and the roof leaks and keeps leaking.

Something should be done about our health insurance. It's getting so high that we cannot afford to have health insurance.

A lid needs to be put on the price of medicine. It's out of reach of many and some probably have to [illegible] without food to get their medicine. The hospitals are charging huge sums for services that they do not render and for material that they do not use.

Medicare needs to revise their forms and billings so the elderly person can understand them. I also think medicare should inform you if your claim was sent to Blue Shield and in case you've been

hospitalized, let you know they have paid your hospital bill and save the elderly three or four months of anxiety before you finally write to be reassured.

Medicare does not pay for X-rays but in some cases, they say you have to be X-rayed before they will pay. So then your other insurance has to pay the bill for the X-rays that they required. Therefore, insurance has skyrocketed. It is to the point where the elderly cannot pay for this insurance. I think medicare should raise their premiums and do away with Blue Shield and take complete charge of our health insurance. Blue Shield is so long paying on your claim, you forget if you were paid, or not. Getting copies made and transportation is also a problem for the elderly.

Never go into debt more than 15 to 20 percent of your wages and try to have your home paid for before you retire and buy wisely. Start early to save on a small scale with passbook savings that you can draw out for emergency without penalty. A lesser percent is paid on passbook so when your savings has grown enough, you should convert to a certificate of deposit or a money market which pays more interest.

When able, set up a trust or retirement fund, thereby saving tax dollars. Life insurance is a good investment if taken out early. This can be set up as a trust and when it has cash value, you can reinvest in something more profitable. Burial insurance should be considered. Find a job with a reliable company and stay with them so you will have a retirement pension when you retire.

To avoid probate costs, put all your personal property, savings and real estate in someone else's name. Cnecking accounts and bank deposit boxes should be in other people's names so they can carry on your business for you. Make a will and designate who you want to have specific things.

Up to this time, much has been done for the low-income and elderly. Now, some testimony from the good old days.

I look back on my life in the early 1900's, as one of 12 children and see a wonderful change. My parents were very poor, but we were happy and content, a lot more so than today, perhaps. My teen years were in the roaring twenties and I worked for my room and board and tuition to be able to go to high school. It was still in the roaring twenties when I got married. We lived on a 300-acre farm for 5 years, each year being able to get only one crop. The drought and flood put us in a bad situation. We hauled corn by horse and wagon, over gumbo roads 24 miles for 19 cents a bushel. In the 1930's, our stock was starving so we applied and got a loan from the Government. We were never able to repay this until in the forties, when I went to work at the defense plant and paid this loan off.

In the early forties, at the death of my mother, my dad came to live with us. At this time, we had three children and lived on a 40-acre farm with cows, chickens, et cetera, selling a few eggs and cream for spending money. We had to separate the milk so we could have cream to sell. My husband worked out for $1 a day and his lunch.

My father had applied for old age pension, but his caseworker said we were in too good circumstances, so he should go live with my sister who had eight children and already on welfare. This he

did, and the week he died, at age 70 years, he got a check for $12. His was a rare case, as most elderly at this time could not live in with their children and draw welfare. Many lived in spruced up brooder houses and smokehouses.

Our senior citizens have much better care now than they did then. Let us do all we can to continue to give our elderly better care and consideration.

Thank you.

Mr. SKELTON. Thank you all so much for coming. I will ask Mrs. Selma Rinne, who, I might add, is from Higginsville, if you have any comments.

STATEMENT OF SELMA RINNE

Mrs. RINNE. I am Selma Rinne, age 71. I have lived at my present address, 2004 Peach, for the past 14 years.

I was born at home on a farm near Mayview, Mo., because hospitals were too far away. Since the horse and buggy was our only transportation then, we had to depend on a country doctor for services. At lot of surgery was done at the local doctor's office and some was done in the homes.

We walked 1½ miles to a country school, where grades one through eight were taught by one teacher. She was paid $150 a month, which was a good salary at that time. Most teachers were only paid about $100 a month, but she was so good, they paid her extra to keep her. Her husband brought her to the school in a horse and buggy every day. My sisters and I were lucky that our parents believed in education. Our father drove a pickup truck and took us and the neighborhood children, without pay, driving 13 miles every day during our high school days to Higginsville, which had the best school system. We paid $6 a month tuition per child.

My father made this drive for 9 years, until we were all out of high school. He not only took the neighbor children, he also ran errands for neighbors, like getting groceries and things as he went back and forth to school.

We children had chores on the farm and did not get to go out at night for entertainment. We had to study by kerosene lamps and carry water from a well. Our washing was done on a washboard until we could afford a hand-powered washing machine. Later, we built a new home with an eletric powerplant in our basement, so we could have electric lights.

We had crop failures through floods and droughts, the same as now, but prices were much cheaper then for things we bought. I can remember hogs selling as cheap as $1.25 per hundred. We had a garden and lived from it the year around. We bought flour and sugar in 100-pound sacks in the fall and prepared to be snowed in for 6 weeks at a time. We lived a more relaxed life then and neighbors worked together to keep from hiring help. Nowadays, we live in a very fast pace and hardly know our neighbors.

It takes money for everything we do. Incomes are higher but we don't have any more money because everything we buy costs more every year. Prices keep going up.

Each year insurance premiums go up, until senior citizens on limited incomes can't afford to keep insurance. And as far as doc-

tors, office calls are going so high and have to be paid each visit so it prohibits a lot of poor folks from going to the doctor. The Government should put a lid on medical charges.

I don't know how elderly people are going to be able to pay phone bills in the near future. They are the ones who really need phones to get help in case of fire and sickness and for a lot of them, it is their only recreation and contact with friends and family. Something needs to be done to stop this increase in rates.

The same is true of gas for fuel. For instance, how can a person getting a social security check for $175 pay a $100 gas bill and live the rest of the month? Where is the utility bill and grocery money coming from?

I think the minimum social security payment for handicapped people over 65 should be raised so they can maintain their homes. Many people near their 75th birthday never worked under social security or made such low wages, it didn't build up very much. I would like to see a bill passed to tax the social security payments in higher income brackets, say $25,000 for singles and $32,000 for married couples, which would help social security stay more solvent and not tax our young people so heavy.

I feel that people on welfare should have to do some work for the Government to make them earn and appreciate the welfare benefits, such as food stamps, ADC, and other benefits. They could clean office buildings, wash windows, and mow lawns, instead of sitting at home, having babies for the Government to support. People on welfare are afraid to work for fear their checks will be taken away. It takes all their initiative away, as well as pride. I think the Government should require Government housing be inspected each year to see that this housing is kept in good condition, the same as they do when people in the Armed Forces live in base housing. They have to leave that house just like it was when they moved in, clean. I have seen low-income houses not fit to live in after 2 or 3 years.

Many people will not hire anyone past 55 years old because they feel at that age, they can't produce. Many people over 65 are willing and able to produce more than younger people because of the experience they have had. Older workers are reliable, easy to get along with and will give 8 hours work for 8 hours pay. Older job hunters tend to fare well in contrast to younger applicants. They dress and present themselves nicely. They are fit and feeling well and make a good impression. Many people 55 to 62, tend to have been bumped out of a job or pushed into early retirement. From 62 years on up, the greater percentage have been retired and are looking to become more active. Most want part-time jobs. Working is not so much an economic necessity for them in some cases.

I feel that children should be required to take a course in high school, teaching them to start savings accounts while they are making good salaries, instead of buying on time payments, which is a temptation to overspend and cause heavy debts, which are hard to pay back and this can cause family problems, which can lead to divorce.

People should plan before age 60 for retirement. It is good to have some work that you can enjoy doing after retirement. If this is not planned ahead, much money can be lost, trying out different

hobbies or work which will make you happy. We need to have something to make us get up every morning.

Like George Burns said:

> Don't ever retire. To live to a ripe old age, we need to keep busy at some kind of work, not just play golf. If you can play golf any time, it loses its glitter, but to play golf after a day's work makes it fun.

As for the future for our children and grandchildren, if our Government could balance the budget, our social security would be secure in that money paid into the program would not be used for other purposes, also. I would like to see an account started for each individual, similar to an IRA account, interest-bearing account. Then, upon the death of an individual and spouse, the accrued interest would be available for the general fund only in the social security system.

Also, individuals earning $25,000 and married couples earning $32,000 might be contacted as to whether they would voluntarily leave their social security payments in their account, drawing interest, until such time as they feel the need to draw on their account. Then, in the event of their death, money accrued in that account could go in the general social security fund, keeping it more solvent.

I thank you.

Mr. SKELTON. Thank you for your comments.

Mrs. RINNE. I talked to State Representative David Rauch last Saturday and he said that they had been to Europe 2 years ago and they had the same telephone system there then that we are supposed to be getting now and he said he thanked the Lord then that the United States still had a telephone system that everybody could afford. And he said here now it is in our business.

Mr. SKELTON. We have a serious problem.

Congressman Daub.

Mr. DAUB. I want to set the record straight, Mrs. Taylor, on the comment you made about having people think about putting their property in someone else's name. That could be very, very dangerous because if the person you give your property to died first, you could have a lot of trouble getting it back. I want to offer the observation that this transfer does not necessarily solve problems concerning the earnings test for food stamps or income tests for low energy assistance because by doing this you take a great risk that somebody else could end up legally being the owner of your assets. It happens all the time. I see the letters come in from all over the country where somebody advised someone to put their assets in another persons name, then that person, who might have the CD in the bank in their name, died and they can't get their money back. So, it is a big risk. I would just urge you to be careful before you do that.

Mrs. TAYLOR. You mean not even your children?

Mr. DAUB. Well, that's the same thing. It doesn't make any difference. If their name is legally on your assets and you don't have a will then in the case that you're the surviving grandparent your assets will go on their kids. The banker doesn't have any choice. You can say: "Well, that was my money, my daughter was just keeping it for me," and it won't make any difference. I'm not

saying you shouldn't do it but, personally, as lawyer, I don't think anybody should do that. I would never give anybody that advice.

Mrs. TAYLOR. I have been advised that's what you should do.

Mr. DAUB. It could be a big problem. I'm the kind of Member of Congress that doesn't want to be critical at all. I am sure someone told you that. I just want you to know that could be very bad advice.

Mrs. TAYLOR. To save you probate costs?

Mr. DAUB. It won't save probate costs any more because the Taft Act of 1981 has made nearly everyone's estate pretty near taxfree, as far as Federal or State taxes are concerned. You may still have a Missouri State tax, I don't know what your law is here. However, it's not nearly as heavy a burden for State tax as it used to be because we've repealed about all of the Federal and area taxes that exist.

Mrs. TAYLOR. Then you should just leave it in your own name and have a will.

Mr. DAUB. Well, I think that your own name, plus a will is the wise way, under these circumstances, especially if you have more than $10,000 in liquid assets in your name. There are good lawyers here in your district to give you good advice. Don't just give your property, be it cash or land, to somebody else because you think you're going to avoid probate or qualifying for special programs, because that will not necessarily work.

Now, let me get to the notch. You're going to get questions everywhere you go about the "Dear Abby" letter. Some of you probably read it.

If you don't know what "Dear Abby" wrote, after I give you this explanation, you will be informed about what she said. It will be up to you to decide whether to believe "Dear Abby" or me.

"Dear Abby" published a letter from someone who signed it "A Notch Baby." "Dear Abby" commented in her response that she had checked out the facts of the letter and "they are accurate." She concluded by telling readers to write their Congressman.

In the "notch baby" letter, it said that there was a law that was passed in 1977, that was going to cause everyone born after 1921, when they retire, to have their social security benefit cut $100 a month. I read that in my Omaha World Herald, because I happened to be home in Omaha when it was published. It was the same day it crossed most of the country since it is a syndicated column out of Kansas City. I picked up the phone and called the syndicated column office in Kansas City. I was probably the 1,300 or 1,400 person who had called in. That poor fellow didn't know what to do.

He said: "Well, we checked this out with a social security official in Los Angeles." I tracked down that office and immediately sent an airmail, overnight, special delivery letter to "Dear Abby," who has a married name, however, and I won't tell you what it is. I got her personal home phone number and address.

She called me the next morning, long distance, and we visited. I simply said to her: "It's not so much what you said but it's what you didn't say. Nobody is going to have their social security benefit cut $100 a month." That's $1,200 a year. No Member of Congress in his or her right mind would ever vote for anything like that. Our

policy is to never touch benefits that were paid in the past, although we may change them in the future, depending on the circumstances. The simple fact of the matter is that today, just like in 1972, your social security benefits are calculated the same way. That is to say, three things are in the formula: how much you paid in, and/or your employer if you were working and getting a W-2; your average wage level—not just your wages in total but the average of your highest 5 years or 60 months; and the third thing is the cost-of-living index that is paid every year. It used to be paid every July 1. We changed that this year, and it will be paid every January 1 from now on. Those are the three things. Since Congress didn't want to face having to vote on a social security increase every year which was too politically sensitive. Under the 1972 law, it was decided that the formula would be indexed every year, therefore making increases automatic. When this was done, Congess neglected the fact that wage levels, the highest average of your best years which will yield the highest benefit on the table also takes into account increasing inflation. Therefore, because of that change in the law, from 1972 to 1978, retired persons were getting a double benefit, or a windfall, because inflation was being calculated twice. Those people who retired in years prior to 1979 were getting a double benefit from the calculation of inflation into their earnings table. The 1978 Congress changed that and the so-called notch years occurred. This is where the "notch baby" term came from. Those persons who were born between 1917 and 1921—the notch years—were phased out of the double inflation benefit and from now on recipients will only get one inflation benefit This increase will not be from the wage level—because this has already happened—but from the CPI. The calculation of inflation, will be indexed every year and contribute to the person's social security benefits. What this person who wrote to "Dear Abby" said is incorrect. I don't know of anybody who will be cut anything at all. They may not get as great an increase as they might otherwise have received if the formula had not been corrected.

Mrs. TAYLOR. During those years?

Mr. DAUB. No; for everybody after 1984. You just won't get two benefit calculations. It was never intended. No one is going to get cut. What you might say is this: Your increase has been reduced a little bit by taking away two calculations for inflation. After all, if you think about it, it is rather fair; isn't it? That money has to come from somewhere and you and I both know where it comes from. It comes from workers, our children and grandchildren in the system. To correct this and pay for two inflation calculations like people born before 1917 received, it would mean we'd have to raise taxes on the workers or cut somebody else's social security benefits. It's been calculated that to change the formula to the way it was before 1977 would cost $8 billion in the first 3 years. We know how tentatively balanced social security is right now, although I think it's in a lot better shape now than it was a year ago.

It's just a factor of fairness. I think that Congress acted very responsibly and nobody's going to lose anything.

Mr. SKELTON. Thank you.

Mr. Porter, you referred to the eyeglass, medicare, hearing aid, et cetera, dentures, there is a bill that Congresswoman Mikulski in-

troduced, of which I'm a cosponsor, relating to assistance with eyeglasses. As of this moment, I don't see any hope for it this year or even this Congress, because of the fiscal condition in which we find ourselves, but there have been no hearings scheduled.

Should there ever be a change and addition, which would you like to see some assistance on?

Mrs. MIKELS. Personally, I would rather see the dentures, but it would depend. But it might not be the best thing.

Mr. DAUB. Would the gentleman yield?

Mr. SKELTON. Yes.

Mr. DAUB. I thank the gentleman for yielding.

I just have one comment that you so eloquently pointed out in your statement and that is that no one ever dreamed how terrific it is that we've got the medicare program. Nobody else anywhere in the world gets as good a quality of medical care for the elderly as one does in this country. We never dreamed when we started this program that it would be paying the full cost of a pacemaker, kidney, heart/lung, and many things that are very expensive.

The problem is, then, if you add eyeglasses and dentures, canes and walkers, prosthetic devices, all these things, how do we balance the system? The program will shrink, just of its own weight, to a disastrous consequence, resulting in our cutting something even more important. Remember, fewer births and fewer deaths means that in 1991, we're going to have fewer workers carrying a heavier load. That means fewer taxpayers contributing to the medicare/medicaid trust fund which comes out of the payroll taxes. I don't know where we're going to find the money for some things. I wish we could. I'd like to. I will be very honest with you and say that I think the basic medical coverage that we've got now is the one thing we've got to protect first.

Mr. SKELTON. There has been a running strain through some of the testimony here today, the concern about—and fear in some cases—crime and being victimized in one fashion or another. I heard the earlier panel in Jefferson City and we've heard it from you folks. The fact that crime has gone down in America some 4 percent this past year, still doesn't alleviate the fact that it is on everyone's mind. I'm not sure there is an easy answer. Most crime, as you know, is not a Federal crime, it's local, State, county violations.

One thing we can do is assist law enforcement officers. I am a former prosecuting attorney myself and if there is anything that concerned me a great deal was to have someone that we caught, one way or the other, and then the complaining witness not cooperate or not come in to testify. I know it is difficult, I know it is embarrassing but it is terribly important that there be cooperation with the sheriff, the highway patrol, the prosecuting attorney, because if you don't, somebody else is going to be a victim.

So I just throw that out that should those unpleasant things happen to you, I would suggest full cooperation. I know it's difficult to get on the witness stand sometimes but give all the full information you possibly can to the law enforcement officials.

If people will stand with their law enforcement officials, whether State or Federal, a great deal of assistance will come to pass.

Congressman Daub, do you have any closing statements?

Mr. DAUB. I don't have a closing statement but I do want to ask permission, on behalf of all of the fine constituents you represent in Congress, if there are any here who would like to submit testimony. I would ask the record be held open, if you would so rule, for 30 days, in case letters and other testimony might come to your attention that you wish to include in the record.

My father is 72 years old and at age 68 he quit working. At age 69, he had an esophagus eruption, which 10 years ago he wouldn't have lived through. With the miracle of wonderful medical surgery and a lot of commitment and prayers, he survived. Although he now weighs 115 pounds compared to the 220 pounds he weighed when he went into the hospital, his bills total $151,000. That's taken a good deal of my parents savings. Thank God for medicare and medicaid and for family, and also for supplemental insurance packages. I will, however tell you something that all of us need to do as consumers, that is to read the medical bills when they come to you. He wouldn't have done it.

No matter how simplified we make them, somebody is going to have to present the patient with a piece of paper that itemizes the charges. If you can't understand it, try to ask a neighbor or a friend or a visiting nurse or somebody to explain the bill. If I hadn't read those bills I wouldn't have realized that the medicaid system would have paid for a number of things that my father did not receive. I asked the hospital why that was the case. They gave me a pretty good answer. They said:

> We have certain things that are programmed for the intensive care unit. We never know who is going to be in there. It could be an automobile victim from a drunk driver, it could be a heart attack, you never know. But, we have to have that room completely equipped to handle any health emergency.

So some of the things in the intensive care unit are there that you may not think you need. However, that's what that room is all about. And that's how the hospital is able to pay for the equipment.

Second, they said:

> We have a computer and if we have somebody standing at the door 24 hours a day marking pads, syringes, rubber gloves, IV stands and all the things that we had to specially order into the room for each patient, it would take a lot of time. Our overhead would go up because we were keeping track of every little thing to be sure you didn't have any objections to your bill.

Maybe you have never thought about this, but I did write out the things I know he didn't get, and they subtracted them from the bill and medicare wasn't charged for it.

We all, at some time in our life, pay for medicare and we want it to be there for our children and grandchildren. If I could make a suggestion, that is that we all have got to do our part, too. No matter how simple a system gets, somebody needs to check. We should always encourage our children to look at our bills as we get older. There are so many of these bills. One of the biggest criticisms we have is the number of ripoff's in the system, and I am sure that goes on. Some of this will stop if people know we're watching and checking.

I just can't tell you how rewarding it's been, Congressman Skelton, my good friend and colleague, for me to be here today and I thank you. I appreciate this opportunity. I know I've grown a lot

and learned a lot. The panels we've had this afternoon were particularly enjoyable.

Mr. SKELTON. Special thanks to Congressman Daub for taking the whole day and coming to Missouri and listening to my people, the people I represent. We've heard a lot of testimony, starting early this morning and ending now. We now take this record that the good court reporter will put together for us and it will be submitted to the entire Committee on the Aging.

We will be dealing with some difficult questions on aging and regarding senior citizens, many of them in the area of programs, many in the area of taxation, many of them in the area of health. What you have done in taking your time today helps us in our thoughts and our debate. We have some tough questions to decide. We hope that we stand in your shoes, whether they be Nebraska shoes or Missouri shoes, you would understand and know that we have gathered the best information that we possibly could.

I might also remind you that those of you who wish to submit testimony, either in letter or formal form, to send it to me in my Washington office, and we will include it in the record set forth. The record will be open for 30 days from this day.

Ladies and gentlemen, you have been a part of this wonderful thing called democracy. It works, it really does. As long as we can have people such as you take an afternoon off to come in and visit with you and as long as we have congressmen that will come to another district and listen to thoughts and suggestions, this whole process is going to last a long, long time.

Among the comments we heard today were comments that can be portrayed as only being patriotic and I thank you. Those of us that spend our time in Congress draw strength from that type of comment. This is a wonderful land and you are helping keep it that way.

Thank you so much for being with us and God bless you.

[At 4:02 p.m., the hearing was adjourned.]

APPENDIX

PREPARED STATEMENT OF NORM HOLLAND, BARNETT, MO.

1. We presently have and will always have a certain percentage of people who are in dire positions for expenses and no income and cannot provide for themselves.
2. Some of these people are in this position thru no fault of their own, and could not possibly plan or take part in pre-retirement planning act earlier.
3. Our Government has dome an exceedingly fine job in the past to help these unfortunate people.
4. One of the programs has been paying nursing homes or other medical institutions for their care, and a built in cost of living index to take care of inflation.
5. During the middle 1970's our Government investigated and decided these people should receive a $25.00 a month check for personal use, and the Government also set an amount to be paid for medical costs and nursing homes.
6. To the best of my knowledge everyone connected with government and almost all of the people in private enterprise has had cost of living increases during the last 6 to 8 years, except the unfortunate one's receiving the $25.00 a month.
7. If $25.00 was fair in 1976, it isn't fair in 1983, and they have actually taken a 40 percent cut in income during this time due to inflation, which they have no control.
8. I would like to see congress mandate by law a fair increase to these unfortunate people, and also an automatic cost of living like we have in social security to protect them in the future.
9. We are doing this now for our able bodied senior citizens, on social security, civil service, military personnel, just to mention a few, so why continue to exclude those who need it the most.

P.O. Box 7,
Urich, Mo., October 10, 1983.

Hon. IKE SKELTON,
Chairman, House Select Committee on Aging,
Washington, D.C.

DEAR MR. SKELTON: I considered it a privilege to be able to attend the field hearing of the House Select Committee on Aging in Clinton, Mo., September 16, 1983. I understood that those of us who attended were invited to express our opinions in writing to the Committee within thirty days.

In January 1982 my husband retired and began drawing Social Security at age sixty-five, largely because of health reasons. I also draw a spouse's Social Security check on his earning record. I have been familiar with my parents, my husband's parents, and one of his aunt's financial affairs. Social Security, Civil Service Retirement, Medicare and Medicaid have been generous with these older members of our family. Ill health, inflation and inflated health care costs have been the real "villains." Aunt Hattie was adequately cared for by Medicaid for more than four years after five years of ill health and nursing home care exhausted her estate of more than thirty thousand dollars. My mother-in-law's care in a nursing home has been paid for by Medicaid after her savings were gone.

Mr. Skelton, I do not believe Medicare should be extended to pay for such items as eye glasses, hearing aids, and routine dental care. The great majority of Medicare recipients can, by wise management, afford these routine health care expenses, and, for those who cannot, Medicaid would be the logical answer.

The biggest injustice I have encountered with Medicare is the provisions that a hospital benefit period does not end if the patient enters a nursing home following hospitalization. (Page 10, Medicare Handbook, January 1981 edition) For example, Aunt Hattie entered the hospital in May 1972 because of a combination of illnesses.

She had to enter a nursing home when her hospitalization ended. She suffered a broken hip three years later, two years after the hip fracture one leg was amputated, a few months later the other leg was also amputated, and finally a few weeks before her death in December 1981, she suffered a stroke. Medicare treated all these illnesses over a period of over nine and one half years as one illness within one benefit period. At the time of her death she was into her "life time reserve days". I believe the way Medicare benefit periods are handled should be changed. Because Medicare paid absolutely nothing toward her nursing home care until after the stroke in 1981, I believe a new benefit period should have started after she was out of the hospital sixty days regardless of whether she was in a nursing home or in her own home. This weakness in Medicare is a particular hardship on those who have no family to care for them and for those who, by frugal living and careful management have sufficient means to pay for normal expenses but not enough for prolonged and devastating illnesses. Medicaid did pay for her continued care, and fortunately her mental condition was such that she never realized that she was on "welfare".

I appreciated Mr. Daub's statement warning us about giving away property to beat inheritance taxes or to get on Medicaid rolls. Our own lawyer warned my mother along those same lines when he helped her draw up her will. Upon his advice, she retained ownership of her property. Of course her very modest estate will soon be gone if she should suffer extended illness or have to enter a nursing home.

I hope you and the Committee especially noted the pleas of several persons who attended the meeting to keep Social Security taxes as low as possible. Most of us on Social Security are parents and we are just as concerned that our children are not unduly burdened by excessive Social Security taxes as we are about our own benefits.

I commend the Committee for investigating the advertising tactics of those who sell supplementary insurance for Medicare recipients.

I would be opposed to requiring the public schools (elementary and secondary) to provide courses on financial planning for aging because such matters should be left to local government. Most of us do not learn very well until we experience a need to know. Newspapers and magazines do carry informative articles along these lines. Governmental agencies, radio, and television are potential means of educating the adult public.

I strongly urge the members of Congress to make it a top priority to act to reduce the spending of the national government in every reasonable way and to hold tax increases to the lowest possible level necessary to achieve a balanced budget. This means that government spending for all purposes except possibly benefits to the extermely poor will have to be cut or held at present levels. Before any new programs are started or present programs are extended, members of Congress should ask several questions. Can we afford this program? How will this program be funded? Can state or local governments take care of these needs more effectively or with less expense? Only in this way can inflation be prevented from destroying the economic security of the great majority of Americans of limited or modest means.

Sincerely,

MARY FERN KELSAY.